Adirondack Health Institute

Lead Empower Innovate

# POLICY AND PROCEDURE

***Title***: Health Home Plus for HIV/AIDS

***Department***: Health Home

***Intended Population:*** Health Home Serving Adults

***Effective Date:*** 5/1/2019

***Date Revised:*** 7/17/2019; 5/10/2021; 2/1/2023; 4/1/2024

DOH Guidance: HH Plus for Individuals with HIV

Program Guidance: HHCM for People living with or at Risk of HIV

HH+ Attestation

**Purpose of Policy**

To describe who qualifies for Health Home Plus HIV/AIDS, describe the needed documentation from Health Home Service Providers, and the minimum service requirements and education to serve this population.

**Scope**

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions, problems, or compliance issues with the policy within ten days of the issue date to the AHI's Health Home Assistant Director.
3. All questions regarding this policy or its implementation may be directed to the Health Home Director.

**Statement of Policy**

AHI shall develop, disseminate, and review at least annually a Health Home Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Health Home Policy.

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**Definitions**

***AHIHH:*** AHI Health Home, a designated lead Health Home by the New York State Department of Health

***Health Home Network Partners:*** The group of medical, behavioral, social services, and other community-based organizations by which a Health Home Participant receives services to address needs identified on the comprehensive care management plan developed by the Health Home Participant's AHI Health Home Services Provider.
***Health Home Participant:*** A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for care management.

***Health Home Service Provider:*** An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

***Care Management Record System***: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

***Workforce member*** means Employees, board members, volunteers, interns, independent contractors, vendors, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity. This includes full and part time employees, affiliates, associates, volunteers, and staff from third party entities who provide service to the covered entity.

***Single Point of Access (SPOA):*** The Single Point of Access (SPOA) is under the authority of the Local Government Unit (LGU) and Mental Hygiene law. SPOA is a critical entry point for the mental health service delivery system

***SMI:*** Serious mental illness

***AOT:*** Assisted outpatient treatment

***HUD*****:** Housing & Urban Development

***HUD homeless definition***: An individual who lacks a fixed, regular, and adequate nighttime residence. For example, the member 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 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.

***Unsuppressed viral load (VL) in HIV+ persons on antiretroviral therapy (ART)***: occurs when treatment fails to suppress a person's VL and is associated with decreased survival and increased HIV transmission. An unsuppressed viral load is defined as a viral load > 200 copies per mL.

**Background**

The Health Home Plus Program Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

**POLICY**

Health Home Plus (HH+) is an intensive care management program established to provide Health Home members with the intensive services needed to stabilize their health and social service needs in the community. HH+ supports Persons Living with HIV (PLWH) by addressing barriers to positive health outcomes, adhering to HIV care and treatment, and achieving viral suppression. The New York State Department of Health (NYSDOH) expanded the eligible HH+ target population to include individuals who are HIV+ and virally unsuppressed.

The HH+ Program for individuals with HIV is intended to align the Ending the Epidemic (ETE) Initiative's objective to achieve viral suppression with the Health Home model of care. By recognizing HIV+ individuals with detectable viral load and those encountering psycho-social barriers to achieving viral suppression warrant the highest intensity of care, the expanded HH+ program will support PLWH achieve viral load suppression and address barriers to maintaining health and adhering to care and treatment.

**<u>Eligible Population</u>**

This guidance applies to the HH+ categories of care provided to Health Home members receiving care management services. These include **individuals who are HIV+ and:**

1. Not virally suppressed (Viral load > 200 copies per mL) **OR**

2. Have behavioral health conditions (SMI, and/or engage in Intravenous Drug Use) regardless of viral load status; **AND**

- Had three or more in-patient hospitalizations within the last 12 months.

**OR**

- Four or more Emergency Room visits within the last 12 months.

**OR**

- Homelessness at time of eligibility (Housing & Urban Development's [HUD] Category One (1) 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.

OR

**Clinical Discretion**: MCOs and medical providers have clinical discretion to refer individuals into the HH+ category. For medical providers, there is no standard template for clinical discretion but clinical discretion requests from providers must include:

- Status of an individual's viral load **AND**
- Factors that indicate the need for referral into HH+ or a continuation of services such as: newly diagnosed HIV status, viral load suppression is not stable, housing instabilities, poor adherence to treatment plan, etc.

**<u>Members who are Eligible for HIV and SMI Health Home Plus</u>**

HHSP's should determine the most appropriate HH+ assignment for a member who is diagnosed with both SMI and HIV. Members who are eligible for both HIV and SMI HH+ should be served at a level of intensity consistent with the requirements of HH+. When working with a member who meets the eligibility criteria for both SMI and HIV HH+, a determination must be made by the HHSP regarding the most appropriate program to serve the member's needs while also respecting the member's choice.

The HHSP and member must evaluate the most pressing concerns are for the member and the root cause of their instability. The Plan of Care should address the dual needs of the member. For example, if the member is virally unsuppressed, the need to work toward an adherence/treatment goal might be a priority. If the members SMI is also uncontrolled, then this too should be a goal. In such cases, supervisory staff should review the members' wants and needs, review the plan of care, and ensure that the appropriate medical and mental health providers are included on the members' care team. The HHSP supervisor should actively work with the care manager to ensure that the needs of the members are being appropriately addressed.

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**Referral for Health Home Plus**

Referrals can come from multiple sources including community providers, behavioral health providers, MCOs, hospitals and/or other healthcare providers. The referral source can supply documentation verifying that the individual meets the requirements for HH+ services. Once a referral is received by the Health Home network, the Health Home Lead will ensure the individual is promptly assigned to a HHSP qualified to serve the HH+ population.

**HHSP's Eligible to Serve HH+ HIV/AIDS Members (Provider Qualifications)**

All legacy COBRA HIV TCMs are eligible to provide HH+ care management services and bill the HH+ rate. The HHSP must attest that they are in compliance with all staffing qualifications, caseload ratios, and training requirements. *See also Staffing Qualifications and Caseload Ratios policies.*

HHSPs that are non-legacy providers may qualify for providing HH+ HIV care management services and bill the HH+ rate if they can attest to the following agency qualifications:

- HHSP is an Article 28 or Article 31 provider, certified home health agency, community health center, community service program, or other community-based organization with:
    - Two years' experience in the case management of persons living with HIV or AIDS; **OR**
    - Three years' experience providing community-based social services to persons living with HIV or AIDS; **OR**
    - Three years' experience providing case management or community-based social services to women, children and families; substance users; Mentally Ill Chemical Abuser (MICA) clients; homeless persons; adolescents; parolees, recently incarcerated; and other high-risk populations and includes one year of HIV related experience.

**Staffing Qualifications *(See Staffing Qualifications Policy for further guidance)***

All legacy and non-legacy HHSPs who qualify for HH+ HIV services and rates must attest that the HH+ staff meets the following minimum qualifications and training requirements:

*Care Management Supervisor:* Minimum qualifications

- Master's degree in health, Human Services, Mental Health, Social Work and one year of supervisory experience and one year of qualifying experience; **OR**
- Bachelor's degree in health, Human Services, Mental Health, Social Work and two years of supervisory experience and three years of qualifying experience**.

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*Care Manager/Coordinator:* Minimum qualifications

- Master's or bachelor's degree in health, Human Services, Education, Social Work, Mental Health and one year of qualifying experience**; **OR**
- Associate degree in health, Human Services, Social Work, Mental Health or certification as an R.N. or L.P.N. and two years of qualifying experience**

*Navigator/Community Health Worker/Peer:* Minimum qualifications

- Ability to read, write, and carry out directions AND
- High School Diploma or GED, OR
- Certified Alcohol and Substance Abuse Counselor (CASAC), OR
- Certification as a Peer (AIDS Institute Peer Certification preferred), **OR**
- Community Health Worker

**Note:** Staff serving HH+ populations should also demonstrate knowledge of community resources, sensitivity towards the target population, cultural competence, and speak the language of the community.

**Qualifying Experience: means verifiable work with the target populations defined as individuals with HIV, history of mental illness, homelessness or substance abuse.

**Staffing Models (*See Caseload Ratios Policy for further guidance)***

***Preferred Caseload***

- The preferred caseload ratio for HH+ members shall be 1 Care Manager to a maximum of 15-20 HH+ members.

For the purpose of case load stratification, a caseload mix of HH+ and non HH+ is allowable if and only if the HH+ ratio is less than 20 members to 1 Health Home Care Manager.

***Mixed Caseloads: The case load comprised of HH+ and non-HH+ individuals***

Care Managers may have a mixed case load. To allow flexibility, medium or low acuity members may be part of a HH+ case load, especially at the beginning of forming HH+ caseloads and teams, in rural areas where fewer cases occur, or as members move to stability but need continuity of care.
One (1) Health Home care manager/coordinator with ten (10) or more HH+ members – max caseload 40 members (inclusive of HH+ members)

***Note:*** *When the number of HH+ clients is extremely low, the care manager supervisor should use discretion to build an appropriately sized caseload. Example: if a HHSP has only 3 members eligible for HH+, the care manager supervisor can work with the care manager to build a caseload that does not exceed NYSDOH caseload limits and allows for the HH+ members to receive the necessary intensive level of services.*

**MODEL 1: HH+ with Care Manager Only**

One (1) Health Home care manager/coordinator – maximum case load of 15-20 members.

MODEL 2: HH+ with Care Management Team

- One (1) Health Home care manager/coordinator plus one (1) peer/navigator/community health worker – maximum case load of 25- 30 members.

- One (1) Health Home care manager/coordinator plus two (2) peer/navigator/community health worker – maximum case load of 35-40 members.
- One care manager/coordinator may supervise no more than two team members.

**Staff Training Requirements**

Care manager/coordinator and peers/navigators/community health worker staff serving individuals in HH+ must meet training requirements established by the AIDS Institute. Personnel records pertaining to these Health Home Standards can be audited by the Health Home at any time and will be discussed at the annual Comprehensive Audit review. .

Training requirements include:

- All core competency content areas completed within the first 18 months of employment, **AND**
- A minimum of 40 hours annually thereafter.

**Core Competency Content Areas**

Core Competency content areas listed below are intended to serve as a training resource guide for all Health Home staff who work with individuals living with HIV. Some webinars have been offered as live webinars, where there is conversation with participants and live Q&A; while others are pre-recorded webinars or online courses. Supervisors should use discretion, look for trainings that addresses the below core competency content areas, and choose the format that best fits the needs of individual staff.

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Core Competency Training Content Areas

- Role of Health Home Care Managers in Improving Health Outcomes for Clients living with HIV
- Introduction to Co-occurring Disorders for Client with HIV
- Introduction to HIV, STIs, and HCV
- Harm Reduction
- Overview of HIV Infection and AIDS
- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) Cultural Competency
- Primary Care and Treatment Adherence for HIV Positive Individuals
- Role of Non-clinicians in Promoting PrEP /PEP
- Sexual Orientation and Gender Identity (SOGI)
- Ending the Epidemic
- HIV/AIDS and Adolescents
- Sexual Health
- Transgender Health
- Substance Use Disorder (SUD)/Drug User Health

**Supervisors:** The training resources listed below provide online/WebEx/Zoom trainings that address a wide range of topics including HIV, sexual health, LGBTQIA+, mental health, substance use, etc. Contact each training resource directly to get on their email listservs. Please, check the content of each training to assist your staff in registering for training that is appropriate for their needs and AI requirements.

**Training Resources:**

• AIDS Institute Training Centers: https://www.hivtrainingny.org/Home/About

• AIDS Institute Training Initiative: https://www.hivtrainingny.org/

• Empire Justice Center: https://empirejustice.org/training/

• Legal Action Center: https://www.lac.org/work/what-we-do/technical-assistance

• NYS Office of Children and Family Services: NYS Mandated Reporter Training courses

• NYS Clinical Education Initiative support@ceitraining.org

• National Council for Mental Wellbeing Communications@TheNationalCouncil.org

• Mountain West AETC aetcinfo+uw.edu@ccsend.com

• National Coalition on Sexual Health https://nationalcoalitionforsexualhealth.org

• Health HIV: https://healthhiv.org/

• MCTAC mctac.info@nyu.edu

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**Service Intensity**

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.

- 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. At least one of these contacts must be with a Care Manager if using the team approach.
  Face-to-Face visits should occur at:
- Assessment
- Reassessment at six months
- Plan of care revisions/update (every 6 months, or before based on the needs of the client).

- The HH+ rate code can only be billed when all service level requirements are met and clearly documented in the individual's record.
- Case conference with all providers and the client must occur every six months, or as needed based on the needs of the client. A reassessment must be conducted at 6 months. The reassessment must include the viral load status and progress towards the goals listed on the Plan of Care.
- If the minimum service requirements are not provided in a given month, but all other requirements are met; and at least 1 Health Home core service was provided the High Risk/High Need rate may be billed.

**Comprehensive Transitional Care**

It is expected that the HH/HHSP 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.

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**Quality Assurance**

Best practice is that the HHSP's should immediately upload supporting documentation within the members' electronic health record. Because supporting documentation for homelessness and SUD can be more difficult to gather, HHSP's shall have more than 90 days to upload such documentation within the member's record. In the interim, the members eligibility status can be substantiated via client self-report or care manager observation. Examples of acceptable supporting documentation are as follows:

- **HIV Status:** Lab results, medical records, or documented conversation from collateral contact (must a service provider or MCO that can confirm lab results and/or have access to the individual's medical record.
- **Homelessness:** Letter from a shelter or other housing program, hospital discharge summary, eviction notice, or self-report. Observation by care manager and documentation of this observation in progress notes and care plan that reflects the intensity of service needs to address this category.
- **Inpatient Stay for Physical Illness:** Hospital discharge summary, documentation of collateral contact of a provider who can verify patients discharge (Note must include: name of contact, title, contact information). Print out from PSYCKES. RHIO alerts or MCO confirmation.
- **Inpatient Stay for Mental Illness:** Hospital discharge summary, documentation of collateral contact of a provider who can verify patients discharge (Note must include: name of contact, title, contact information). Print out from PSYCKES. RHIO alerts or MCO confirmation.
- **Substance Abuse Disorder Active:** Based on assessment and information gathered by the care manager from substance abuse providers, probation/parole, court ordered programs, DSS, or other sources.

**HH+ Attestation**

Prior to billing for HH+ services HHSP's are responsible for submitting the attestation to AHIHH verifying that they can and will meet all the staffing and operational requirements set forth in this policy. *Please see attached HHSP attestation form.*

**General Requirements:**

• HH+ members may stay in the program a maximum of 12 months.

• In cases where extenuating circumstances are documented, and written justification provided; an extension may be granted for recipients to remain in the program an additional 12 months.

**HH+ Stepdown Requirements**

HHSP's must work with members to devise a Stepdown plan prior to transitioning off 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. The HHSP may bill at this rate code for a period of 6 months.

**Quality and Performance**

AHIHH will conduct periodic Care Management Agency Comprehensive Audits to include a sampling of chart reviews of Health Home Plus members and ensure proper supporting documentation is present in the electronic health record and the service needs are reflected in the member's Plan of Care.

**Training**

This policy will be disseminated for review and questions before policy training is given. Due to the extensive knowledge needed to work with this population, additional time is needed outside of the initial policy training. Future in-depth training will be developed or found to understand the Health Home Plus for HIV population, guidance on how to serve this population, and engagement techniques such as Motivational Interviewing which will be provided to all care management staff.

***Contact Person:*** Assistant Director, Care Management and Health Home

***Responsible Person:*** Health Home Service Provider

***Reviewed By:*** Director, Care Management and Health Home

***Approved By:*** Chief Compliance Officer

**POLICY AND PROCEDURE**

**Attachment I**

**NYSDOH/AIDS INSTITUTE Health Home Plus (HH+) for HIV+ Individuals**

**Attestation (LINK)**

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL, Governor | MARY T. BASSETT, M.D., M.P.H., Commissioner | KRISTIN M. PROUD, Acting Executive Deputy Commissioner

**NYSDOH/AIDS INSTITUTE**
**Health Home Plus (HH+) Attestation for HIV+ Individuals**

***To be completed by Health Home programs. HH+ billing cannot begin until attestation forms are received.***

**Name of Health Home:**_____ **Contact Person:**_____
**Contact Person Phone:** _____ **Contact Person E-Mail:**_____

**Instructions for completion or if you need assistance:**

- Complete the NYSDOH/AIDS Institute Health Home Plus Standard Attestation Form below.
- Submit form to: Health Home BML - **Subject: AIDS Institute HH+ Attestations.**

***Department of Health staff will review the information provided and contact your agency if further clarification is needed.***

| | **Health Home Plus Standards**<br>***To affirm Care Management Agency (CMA) compliance with each standard, check box in left column.*** |
|---|---|
| ☐ | Health Home CMA has process for immediate assignment of HH+ eligible members to qualified care managers and the provision of HH+ services, as outlined in the applicable HH+ program guidance. |
| ☐ | Health Home CMA meets Staff Qualification requirements, as outlined in applicable HH+ program guidance. |
| ☐ | Health Home CMA has process to ensure HH+ caseload sizes do not exceed the required ratio of 1 qualified care manager for every **15-20 HH+ recipients**. |
| ☐ | Health Home CMA has process to ensure the minimum service intensity requirements outlined in the applicable HH+ program guidance is met. |
| Additional Requirements for Non-AIDS Institute Legacy and Non-Legacy CMA Providers *(please ensure boxes are checked under each **bolded** subsection below)*: | |
| ☐ | **CMA meets at least one of the following criteria:**<br>Article 28 or 31 provider, certified home health agencies, community health center, community service programs, or other community-based organizations with:<br>• Two years' experience in the case management of persons living with HIV or AIDS; or<br>• Three years' experience providing community based social services to persons living with HIV or AIDS; or<br>• Three years' experience providing case management or community based social services to women, children and families; substance users; MICA clients; homeless persons; adolescents; parolees, recently incarcerated; and other high-risk populations and includes one year of HIV related experience. |

HH+ HIV Attestation, revised May 2022

**POLICY AND PROCEDURE**

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL, Governor | MARY T. BASSETT, M.D., M.P.H., Commissioner | KRISTIN M. PROUD, Acting Executive Deputy Commissioner

| | |
|---|---|
| ☐ | **CMA is in positive standing with all HHs and Managed Care Organizations (MCO)** |
| ☐ | **CMA Supervisor(s), care managers, and peer/navigators meet the following qualifications:**<br>☐ **Care Management Supervisor: Minimum qualifications:**<br>• Master's degree in Health, Human Services, Mental Health, Social Work, one year of supervisory experience and one year of qualifying experience** **or**<br>• Bachelor's degree in Health, Human Services, Mental Health, Social Work and three years of supervisory experience and three years of qualifying experience**.<br>☐ **Care Manager/Coordinator: Minimum qualifications:**<br>• Master's or Bachelor's degree in Health, human services, education, social work, mental health, and one year of qualifying experience** **or**<br>• Associate's degree in health, human services, social work, mental health, or certification as an R.N. or L.P.N. and two years of qualifying experience**.<br>☐ **Navigator/Community Health Worker/Peer: Minimum qualifications:**<br>• High School Diploma or GED, **or**<br>• CASAC, **or**<br>• Certification as a Peer, **or**<br>• Community Health Worker, **and**<br>• Ability to read, write and carry out directions<br>***Community resident with knowledge of community resources, sensitivity towards the target population, culturally competent, and speaks the language of the community preferred.)***<br>***QUALIFYING EXPERIENCE** means verifiable work with the target populations: individuals with HIV, history of mental illness, homelessness, or substance use.* |

**Training requirements for Health Home CMAs serving individuals who are HIV+**

Care Manager/Coordinator and Navigator/Community Health Worker/Peer level staff serving individuals with HIV in HH+ must meet training requirements as stated in the Health Home Plus Program Guidance for Individuals with HIV established by the AIDS Institute.

**All** core competency training content areas must be completed within the first 18 months of employment.

A minimum of **40 hours annually** for staff who have completed their first year of employment.

**POLICY AND PROCEDURE**

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL, Governor
MARY T. BASSETT, M.D., M.P.H., Commissioner
KRISTIN M. PROUD, Acting Executive Deputy Commissioner

**Please use the section below to list ALL contracted Care Management Agencies (CMAs), including AIDS Institute (AI) Legacy Providers who previously attested to meeting HH+ qualifications to which this HH+ Attestation will apply.** When including the name of the CMA, please ensure that the name on this form matches exactly to how the name is displayed in the Medicaid Analytics Performance Portal (MAPP).

**Please use column "CMA Changes" to notify DOH of any changes, including but not limited to changes in HH+ population(s), and adding or removing CMAs.**

**For each CMA listed, indicate with an "X" in the appropriate column(s) – if CMA is an AI Legacy or Non-AI Legacy provider; and if CMA is qualified to serve and bill the HH+ rate code.**
Mark all that apply.

| **Name of Care Management Agency** *(As displayed in MAPP)* | **CMA Changes** (If applicable, please mark "Add" or "Remove") | **AI Legacy** (If applicable, please mark "X") | **Non-AI Legacy** (If applicable, please mark "X") | **HH+HIV** (If applicable, please mark "X") |
|---|---|---|---|---|
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**Certification and Acknowledgement**

I certify, on behalf of my agency, that all information contained in this NYSDOH AIDS Institute Health Home Plus Funding Attestation is accurate and true. I have read the attached and agree that my agency will not seek payment at the HH+ rate for members served by Care Management agencies that do not meet the qualifications to serve HH+ individuals. HH+ payments received are subject to recovery upon audit by the State or Managed Care Organization should documentation fail to support payment received.

Health Home Director Name (print) _____ Signature _____ Date _____

HH+ HIV Attestation, revised May 2022

**POLICY AND PROCEDURE**

**Attachment II**

# HH+ Eligibility Crosswalk

| HH+ Qualifying Criteria | Chronic Conditions | | | | Additional Information |
|---|---|---|---|---|---|
| | SMI Only | HIV+ & SMI | HIV+ Only | HIV+ & IDU | |
| AOT (Active) | A | A | | | • Mandatory 4 face-to-face visits per month<br>• May only be served by attested former OMH-Legacy providers |
| CNYPC Discharge | C | C | | | |
| State PC Discharge | C | C | | | |
| AOT (expired in past year) | S | S | | | |
| ACT Step Down | S | S | | | For individuals transitioning from an ACT program to HHOM |
| Enhanced Service Package/Voluntary Agreement | S | S | | | Definition: 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. |
| Clinical Discretion by SPOA | S | S | | | |
| Clinical Discretion by MCO | S | S/H | H | H | The lead HH will assign to the appropriate CMAs based on qualifications. MCO may flag a case for the lead HH as being appropriate for HH+. |
| Clinical Discretion by Medical Provider | | H | H | H | |
| HIV+ Virally Unsuppressed | | H | H | H | Virally unsuppressed is defined as >200 copies per mL |
| Homelessness: HUD Category One Definition | S | S/H | | H | For individuals with both SMI and HIV, the lead HH will assign to the appropriate CMAs based on qualifications and the primary needs of the individual. |
| Three (3) or more inpatient hospitalizations | | H | | H | |
| Four (4) or more ED visits | | H | | H | |
| Three (3) or more psychiatric inpatient hospitalizations in the past year | S | S | | | |
| Four (4) or more psychiatric ED visits within the past year | S | S | | | ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs. |
| Three (3) or more medical inpatient hospitalizations w/ diagnosis of Schizophrenia or Bipolar | S | S | | | |
| Criminal Justice Involvement | S | S | | | • Release from incarceration (jail, prison) within the past year and requires linkage to community resources to avoid reincarceration.<br>• Eligible individuals have been incarcerated due to poor engagement in community services and supports. |
| Ineffectively engaged | S | S | | | • No outpatient mental health services within the last year and two (2) or more psychiatric hospitalizations; or<br>• No outpatient mental health services within the last year and three (3) or more psychiatric ED visits. |

A: Follow HH+ for AOT guidance | C: Follow HH+ for State PC/CNYPC discharge guidance | S: Follow HH+ High Need SMI Guidance | H: Follow HH+ HIV | S/H: Follow guidance based on primary needs of the individual

Individuals may meet eligibility criteria with more than one HH+ population for SMI (AOT, CNYPC/State PC discharges, High Need) and High Risk HIV+. Health Homes are responsible to ensure that referrals for HH+ are distributed to the appropriate CMAs who has attested to serve the specific HH+ populations and most qualified to address the individual's primary needs. As stated in the DOH Standards document, "HH Care Management providers must assign care managers to enrollees based upon care manager experience and defined member characteristics."