Bassett Healthcare Network
Community Health Navigation

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| **Policy Title:**<br>**Standards and Requirements of HH+ Member Service Provision Policy** | **DOH Policy Name:**<br>➢ **Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness**<br>➢ **Program Guidance- Health Home Care Management for People Living with HIV and Persons at Risk for HIV**<br>➢ **Health Home Plus Program Guidance for Individuals with HIV**<br>➢ **HH+ Program Guidance NYS OMH SPC and CNYPC and Corrections-Based Mental Health Units Adult Discharges**<br>**DOH Reference Number:**<br>**Effective Date:**<br>➢ **09/2021**<br>➢ **08/2022**<br>➢ **05/2022**<br>➢ **10/2016** |
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## POLICY STATEMENT

Bassett Community Health Navigation Health Home (BCHNHH) offers intensive Care Management service for a defined populations with Serious Mental Illness (SMI), Assisted Outpatient Treatment (AOT), and/or individuals living with an HIV/AIDS diagnosis who are enrolled. To ensure the intensive needs of the individuals are met, BCHNHH will assure that 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 as required by the Department of Health (DOH) and Office of Mental Health (OMH).

BCHNHH maintains a network of Specialty Mental Health Care Management Agencies to provide such intensive care management services. Each CMA who specializes in serving this population are required to maintain qualified and trained staff to provide services. Each population served via Health Home Plus have unique needs and it is required that the Care Managers (CM) serving each population have knowledge and understanding of their needs.

## SCOPE

BCHNHH has created this policy in an effort to remain compliant with the requirements set forth by the DOH, and OMH regarding service provided to the Health Home Plus population. This policy consolidates program requirements for all eligible HH+ SMI, AOT, and HIV/AIDS populations, includes updated staff qualifications and training. BCHNHH Network Care Management Agencies (CMA) will receive and share this policy with all Health Home staff, who will attest to understanding the requirements Health Home Plus (HH+) services.

## OBJECTIVES

This policy 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. To describe who qualifies for Health Home Plus, describe the needed documentation from Health Home Service Providers, and the minimum service requirements and education to serve this population. Care Managers will be able to utilize this policy and procedure in their provision of intensive care management services. Care Managers will ensure the intensive needs of these individuals are met, and 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.

This policy outlines the differential monthly rate for HH+ is higher compared to the Health Home High Risk/Need Care Management and mainstream Care Management rates and is intended to appropriately reimburse for the intense and consistent support needed for this population. Providers who meet the requirements to serve the HH+ population must submit an attestation to BCHNHH verifying they meet the criteria and can meet the necessary requirements to serve the population.

## DEFINITIONS

**Managed Care Organization (MCO)**
A managed care organization is a health care company or a health plan that is focused on managed care as a model to limit costs, while keeping quality of care high.

**Assisted Outpatient Treatment (AOT)**
“Kendra’s Law” mandates mental health services for a small number of individuals who have difficulty engaging in rehabilitation and can pose a risk to themselves or others in the community. The order is granted in Civil Court.

**Local Government Unit (LGU)**
A political subdivision of this State, including, but not limited to, a county, city, town or other incorporated community or subdivision of the subdivision providing local government service for residents in a geographically limited area of the State as its primary purpose

**Single Point of Access (SPOA)**
The Single Point of Access program helps providers connect people with serious mental illness (SMI) to mental health services that can accommodate them. These services include but are not limited to; connection to treatment, assistance with communication with providers, and assistance with finding benefits.

**Serious Mental Illness (SMI)**
The designation of SMI allows health home services to be delivered to people with mental illness who have difficulty functioning successfully in their relationship, jobs, schools, and other life roles within their chosen community.
For the purposes of Health Home eligibility, SMI is determined by both a diagnosis of mental illness and an impairment that impacts social, vocational, and psychological functioning. While SMI meets the Health Home single qualifying condition eligibility criteria, the functional criteria will determine Health Home service appropriateness criteria.
For a list of qualifying diagnosis and impairments in functioning to qualify as SMI refer to: Definition of Serious Mental Illness for Health Home Eligibility

**Housing Urban Development (HUD) defined Homelessness**
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.

**OMH Legacy provider**
Former OMH Targeted Care Management (TCM) providers

**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.

## ROLES AND RESPONSIBILITIES

### Health Home Administration Responsibilities

1. Assure HH+ referrals are assigned to the appropriate CMA's for the enrollee's HH+ eligibility.
    a. AOT Legacy provider
    b. HIV/AIDS Legacy provider
    c. SMI approved providers
2. Assist eligible CMAs with maintaining their approval and eligibility to serve HH+ members. This will be tracked on a spreadsheet that the BCHNHH admin team will access monthly to review and ensure compliance.
    a. Assure CMA Supervisors will work together to ensure that staff receive the required attestation forms and ensure that all staff are in compliance with all required program standards outlined in this guidance.
    b. CMs eligible and waived to service HH+ eligible members continue to meet qualification and training requirements.
        i. Maintain record of HH+ qualified and waived staff providing HH+ services to enrolled members.
3. Review, assess, and evaluate each month charts to monitor care of HH+ members. In doing so, any concerning findings will result in further training as applicable. These results will be reviewed at the QMP meetings each month to ensure they are being shared with the CMAs.
4. Approve HH+ enrollment within 72 hours of receiving a request from a CMA.
5. Manage billing and tracking of HH+ services in the MAPP HHTS system for all network CMAs.
6. Continued quality management and performance improvement.
7. Provide trainings and resources to all health home employees and network CMAs.

### CMA Supervisor Responsibilities

1. CMA Supervisors shall be proficient in the following:
    a. Target population management and outcomes
    b. Supporting CMAs with members in crisis
    c. Team planning and staff supervision

   d. Addressing barriers in service access
   e. Knowledge and understanding of OMH program policy requirements
2. Develop a protocol for safely transitioning individuals on and off HH+ Care Management services, based on individual need.
3. Develop a protocol to ensure only qualified staff are providing high need services based on education and experience requirements outlined in this policy.
4. Ensure CMs meet the appropriate qualifications and trainings required to serve HH+ populations.
5. Ensure each CM reads, understands, and attests to this policy.

**Care Manager Responsibilities**

1. Meet qualifying criteria and complete required trainings as outlined in this policy.
2. Read, understand, and attest to this policy.
3. Follow this policy and the procedures set forth in this policy when providing services to HH+ members enrolled in services.

## PROCEDURES

### Program Requirements

**CMA Qualifications to Serve HH+ Members**

Care Management Agencies must receive endorsement from the LGU indicating they have or will have a working relationship, as defined below, with the LGU within (3) months of the Health Home submitting the attestation form.

1. A "working relationship" with SPOA includes:

   a. Demonstrated ability and willingness to accept high-need SMI referrals directly from the LGU/SPOA.
   b. Participation in any county SPOA process or committee as applicable.
   c. Knowledge of LGU/SPOA protocols and resources for accessing local mental health services.
   d. Clearly defined communication standards between the CMA, SPOA, and HH AND;
   e. The CMA must meet at least two (2) of the following criteria:
   f. The CMA is operated by an organization that provides OMH-licensed, (funded or certified services), in addition to care management for individuals with SMI. This may include but not limited to: mental health housing, Personalized Recovery Oriented Services (PROS), Article 31 Clinic, and ACT.
   g. The CMA currently serves individuals with SMI.
   h. The CMA demonstrates knowledge of the behavioral health managed care benefit package, and has working relationships/partnerships with the local mental health service delivery system including but not limited to: psychiatric inpatient units, mental health crisis and diversion services, mental health SPOAs, outpatient mental health treatment programs, rehabilitation services and housing.
   i. Only OMH Legacy providers are eligible to serve the AOT population.

CMAs can apply by completing and submitting their attestation forms here: *NYSDOH/AIDS Institute Health Home Plus (HH+) Attestation for HIV+ Individuals*

**Education and Experience Requirements:**

BCHNHH will ensure that staff with education and experience appropriate to serve the high-needed are qualified at all times. HH+ shall always be delivered by a CMA with staff who are qualified to serve the high-need, behavioral health population under appropriate supervision. The following minimum qualifications apply:

a. A master's degree in one of the qualifying fields and one year of experience; or
b. A Bachelor's degree in one of the qualifying fields and two years of experience; or
c. A Credential Alcoholism and Substance Abuse Counselor (CASAC) and two years of experience; or
d. A Bachelor's degree or higher in **any** field with either three years of experience, or two years of experience as a Health Home Care Manager serving the SMI or SED population

Experience shall consist of:

1. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse.
2. Linking individuals with Serious Mental Illness, 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.)

Supervision shall be provided by staff meeting either of the following qualifications:

1. Licensed level healthcare professional with prior experience in a behavioral health setting; or
2. Master's level professional with two years prior supervisory experience in a behavioral health setting.

**Waiver Approval and Experience Requirements**

In rare circumstances, staff may have unique education and/or experience to adequately serve the HH+ SMI population but do not meet the qualifications outlined above. CMAs may apply for a waiver for such staff. Waivers are not intended to be the sole approach for an agency looking to expand capacity in serving the HH+ SMI population. All waivers will be submitted to *Waiver of Qualifications for HH+ SMI and NYS EA Assessors for adult BH HCBS.*

- Under BCHNHH it is required for a Care Manager to be in their role as a CM for a minimum of 6 months prior to requesting a waiver.
- CMAs who receive waiver approvals are responsible for notifying BCHNHH accordingly.
- Waiver approval alone does not authorize any agency to provide/bill for HH+ services; all other applicable requirements authorizing the agency still applies.
    - Please submit all waiver requests online here: Request for Waiver of HH+ SMI and Adult BH HCBS Assessor Qualifications

**Staff Core Competencies for HH+**

Supervisors and direct care management staff shall possess key skills and knowledge for serving high need individuals with SMI, including but not limited to the following areas:

1. 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).

2. Create and leverage relationships with critical behavioral health service providers to plan and coordinate care management needs for high-need SMI individuals including:

    a. Navigating the mental health service system-including ability to make referrals to mental health housing services, crisis intervention/ diversion, peer support services.
    b. Knowledge of the behavioral health managed care benefit package and coordinating care with MCOs (e.g., for HARP members)
    c. Collaborates with inpatient staff and MCO (as applicable) to affect successful transitions out of inpatient or institutional settings
    d. Addressing the quality, adequacy and continuity of services to ensure appropriate support for individuals' mental health and psychosocial needs.

3. 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 but are not limited to:

    a. Motivational Interviewing
    b. Suicide Prevention
    c. Risk Screening
    d. Trauma Informed Care
    e. Person-centered care planning and interventions
    f. Recovery-Oriented Approaches (e.g., Wellness Recovery Action Plans)

**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. The list of approved trainings is below:

    a. The Role of Health Home Care Managers in Improving Health Outcomes for People Living with HIV/AIDS or At Risk For HIV
    b. Intro to Co-occurring Disorders for Client with HIV/AIDS
    c. Intro to HIV, STI's, and HCV
    d. Harm Reduction
    e. Overview of HIV Infection and AIDS
    f. Lesbian, Gay, Bisexual Transgender, Queer, Intersex, and Asexual (LGBTQIA+) Cultural Competency
    g. Primary Care and Treatment Adherence for HIV Positive Individuals
    h. Role of Non-clinicians in Promoting PrEP/PEP
    i. Sexual Orientation and Gender Identity (SOGI)
    j. Ending the Epidemic
    k. HIV/AIDS and Adolescents
    l. Sexual Health
    m. Substance Use Disorder (SUD)/ Drug User health
    n. Transgender Health

All CM's providing HH services must be sufficiently trained to meet the needs of at-risk and HIV+ individuals. All HH staff working with this population must be trained in the core content areas within the first 18 months of employment. Annually, thereafter, a minimum of 20 hours must be completed.

**Identifying Eligible Populations**

BCHNHH and partnering Care Management Agencies must be able to identify individuals who are HH+ eligible. 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 (multiple hospitalizations, incarceration, and homelessness).

Each CMA needs 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 months to support the transition to a less intensive level of care management.

The following individuals may benefit from the enhanced support of HH+ Care Management and would meet the eligibility criteria for **up to 12** consecutive months:

**AOT Eligibility**

1) Individuals on a current AOT order
2) Individuals identified by the Local Government Unit (LGU) as receiving an Enhanced Service Package pursuant to a Voluntary Agreement in lieu of AOT.
    a. Such agreements may be signed by individuals who were otherwise considered for AOT by the LGU, but who agree to adhere to a prescribed community treatment plan rather than be subject to an AOT court order.
    b. 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) Individuals with an expired AOT court order within the past year.

**SMI Eligibility**

1) Individuals discharged from State Psychiatric Centers and those released from Central New York Psychiatric Center (CNYPC) and its corrections-based mental health units.

2) Individuals transitioning off an Assertive Community Treatment (ACT) team to a lower level of service.

3) Individuals meeting the Housing Urban Development's (HUD) Category One – literally homeless definition. Qualifying individuals lack a fixed, regular, and adequate nighttime residence, including individuals who:

    a. Have 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. Are 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. Are exiting an institution where the individual 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

4) Individuals with high rates of inpatient/emergency department (ED) services utilization. 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 one or more of the following:

   a. Three or more psychiatric inpatient hospitalizations within the past year; or
   b. Four or more psychiatric ED visits within the past year; or
   c. Three or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar.

5) Individuals with criminal justice system involvement, including release from incarceration (jail, prison) within the past year. Eligible individuals require linkage to community resources to avoid re-incarceration and may have been incarcerated due to poor engagement in community services and supports.

6) Individuals ineffectively engaged in case, as evidenced by:

   a. No outpatient mental health services within the last year and two or more psychiatric hospitalizations; or
   b. No outpatient mental health services within the last year and three or more psychiatric ED visits.

7) Others based on 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).

   a. 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.
   b. The LGU/SPOA has oversight responsibility for the high-need SMI population and ensures access to appropriate services to meet their needs. The 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.
   c. The exercise of clinical discretion by the LGU/SPOA or MCO may be based on the consideration of social determinants of health or other factors, including but are not limited to:
      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.

**Referrals for Health Home Plus:**

Refer to *BCHN002: Referral, Eligibility Verification, Assignment, Outreach and Enrollment* for guidance on referrals, including referrals from an Excluded Setting such as NYS OMH State Psychiatric Centers, Central New

York Psychiatric Centers or Corrections Based Mental Health Units. In addition to that policy, HH+ referrals have specific requirements as noted below:

Referrals sent through SPOA should be assigned to a Specialty Mental Health CMA. The Single Point of Access (SPOA) is under the authority of the Local Government Unit (LGU) and Metal Hygiene law. SPOA is a critical entry point for the mental health service delivery system. 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.

In addition, most individuals age 18-21 (transition age youth) who are inpatients in a State PC, OMH (Medicaid District 97) will have opened a Medicaid case to cover the inpatient stay. If the youth had coverage prior to the inpatient admission and the case remained open, upon discharge the youth would have an OMH Medicaid case for the inpatient stay as well as an open local district or NYC HRA case. Following discharge, the OMH case would close and the local district/NYC HRA would be notified to resume the youth's coverage.

- If the youth did not have Medicaid coverage prior to admission, or the Medicaid coverage was closed or expired during the inpatient stay, the OMH Medicaid coverage would transition to the new district of responsibility upon discharge. Youth who have coverage through NYSDOH may have to reapply for coverage upon discharge, or their coverage may also continue uninterrupted.

If a Member becomes eligible for HH+ Care Management Services and is already enrolled in the Health Home, their care manager is required to inform the member of their option for intensive care management.

1. If a member wishes to remain with their Care Manager and not receive intensive care management that decision must be clearly documented in the care management record.
2. If the member wishes to transfer to receive intensive Care Management services the CM should refer to BCHN003: *Health Home Member Transfer Policy.*
3. For individuals already enrolled in a HH and being discharged from a State PC or CNYPC, the CMA shall participate in the discharge planning process and have a face-to-face contact with the individual within 48 hours of discharge.
    a. Current best practice indicates that face to face contact with an individual within 24 hours of release from a forensic facility is pivotal to successful engagement for this population.
    b. Coordination of care will likely include the reestablishment of Medicaid benefits for this population, so that individuals have immediate access to all services on their plan of care.
4. For individuals already enrolled and being released from prison with Parole, the care manager should establish contact as soon as possible with the Parole Officer to coordinate efforts for helping the individual follow their mental health discharge plan, which will include care management.

**Caseload Models That Meet HH+ Requirements**

Individuals enrolled in HH+ must receive a level of service intensity consistent with a ration 1:20 caseload. 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 adhere to program requirements outlined in this guidance.

To meet the changing and complex needs of the HH+ populations, 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 apply:

**HH+ Only Caseload**

Only FTE qualified care manager serves a caseload of no more than 20 HH+ individuals

**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 the HH+ ratio is less than or equal to 20 HH+ recipients to one 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.

**Team Approach**

A CMA may choose to use a team approach to serve a HH+ only caseload or a mixed caseload of HH+ and non-HH+ individuals. If a CMA uses a team approach, the following requirements must be met:

- 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 qualified HH+ care manager. For example, a team serving 50 HH+ individuals shall include 2 qualified HH+ care managers.

- A Qualified HH+ care manager must provide at least 2 Health Home core services per month, one 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.

**Member Care**

Program requirements for individuals eligible for HH+ shall be carried out in a manner 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 Health Home core services shall be provided per month, two 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.**
    - For individuals with an active AOT court order, at least four face-to-face contacts shall be made within the month. See below for additional program requirements that must be met in order to receive the HH+ rate for individuals on AOT.

- 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 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.
    - For AOT individuals, the HH+ rate can be billed for as long as the court order is active
    - If an individual eligible for HH+ 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 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 shall inform the Health Home when HH+ eligibility becomes known to the CM and HH+ services will be provided. For AOT individuals, the CMA shall inform BCHNHH when a member has been placed on court order AOT, or when the court order has expired and has not been renewed.
    - BCHNHH shall inform the MCO of the individual's HH+ status.

**High-Risk/High-Need Individuals Identifying Risk**

Member's enrolled in HH Care Management, HIV-positive, virally unsuppressed, and have one of the below co-occurring conditions have unique needs.

1. Transgender individuals not in care.
2. Individuals recently incarcerated within last 6 months or on parole or probation
3. Homelessness in adults and minors.
4. Women who are pregnant and not in care.
5. Women who gave birth within last 12 months and not in care.
6. Men who have sex with men (MSM) who engage in unprotected sex or inject drugs.
7. Individuals who are on PrEP or PEP, based on assessment of continuous risk behaviors.
8. HIV+ individuals who are high utilizers of emergency room services.
9. LGBTQ youth.

Assessing a member's sexual risk, substance use, mental health, and other considerations are essential to developing a complete comprehensive assessment and POC. CM's must complete the HIV/AIDS Assessment Screening within the Comprehensive Assessment to identify a member's risk.

**Documentation in the Care Management Record**

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

1. 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.
2. 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.
3. 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, and contact information). Print out from PSYCKES. RHIO alerts or MCO confirmation.
4. 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, and contact information). Print out from PSYCKES. RHIO alerts or MCO confirmation.
5. Substance Abuse Disorder Active: Based on assessment and information gathered by the care manager from substance abuse providers, probation/parole, and court ordered programs, DSS, or other sources.

**Stepdown Requirements**

CMA'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. CMA's should assist members in developing a plan that assures appropriate service level intensity.

CMAs can bill at an enhanced rate while transitioning a member off HH+. The CMA 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 CMA may bill at this rate code for a period of 6 months.

**Additional Program Requirements for Individuals on AOT**

The following program requirements apply to **all** individuals with a current AOT court order:

- Individuals receiving court ordered AOT will be assigned to a CMA with behavioral health expertise or otherwise qualified to serve HH+ individuals, through the LGU's AOT process.
    - In many counties, SPOA may be included in the process by which the LGU assigns AOT individuals to a CMA.
    - If an individual already receiving HH care management in the community is later ordered to AOT, the LGU shall 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 shall 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.

- At least four face-to-face contacts shall 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.**

- If the care manager made diligent efforts to provide four face-to-face contacts and the individual was not home, did not show up for an appointment, or was otherwise not available, the CMA shall report all efforts made to the LGU using notification procedures developed by the LGU.

    - 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 members record.
    - If at least one Health Home core service was provided by a qualified care manager and the above requirements have been completed:
        - The Health Home High Risk/Need care Management rate code may be billed for that given month.

- If the individual with an AOT court order cannot be located and has 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. The member will be entered into **Diligent Search Efforts, as outlined in the OMH guidance.**

    - If the care manager made effort to provide four 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 individual's care management record.** The individual'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.
        - 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.
    - 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. The CMA shall maintain continued communication with the LGU in order to determine what additional follow-up efforts may be required. All communication shall also be documented clearly in the individual's record.

- When the examining physical 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.

- The CM will work with the LGU to ensure timely delivery of services listed in the court order. Such services shall include coordination of all categories of service listed in the AOT treatment plan.

- All categories of service listed in the court ordered AOT treatment plan shall also be included in the individual's integrated Health Home Plan of Care.

    - The CMA and/or other members of the treatment team shall 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.
    - Changes needed to other services in the HH plan of care that are not listed in the AOT treatment plan (ex. Primary care services not listed in the AOT treatment plan) are not considered material changes and therefore do **not** require consultation with the LGU.
    - Health Homes and Care Management Agencies shall be familiar with the statutory basis of the AOT program, or Kendra's 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.
    - 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 shall report assessment and follow-up data to the Office of Mental Health through the Child and Adult Integrated Reporting System (CAIRS) at 6-month intervals.

**LGU Requirements for AOT**

The LGU is responsible to operate, direct, and supervise their County's AOT program and work in collaboration with the CMA to arrange or provide for all categories of AOT services. As part of these responsibilities the LGU:

- Uses their established system to respond to and investigate all AOT referrals;
- Ensures that the services in the treatment plan are made available and monitors delivery of these services.
- Monitors the AOT individuals served;
- Follows the county-specific procedure for implementation of MHL section 9.60 removal orders;
- Follows their established system for notification regarding AOT recipients who are missing within 24 hours, diligent search, removal orders, and missing person report; and;
- Uses their established system to be notified of all significant events and reports them to OMH as required (refer to *Significant Event Reports: Care Manager Reporting of Significant Events Related to Assisted Outpatient Treatment (AOT) Court Orders);*
- Provides data to OMH as required.

More details on the AOT Program and reporting requirements can be found on the OMH Website.

**Additional Requirements for Individuals Living with HIV/AIDS**

**CMA's Eligible to Serve HH+ HIV/AIDS Members**

All legacy COBRA HIV TCMs are eligible to provide HH+ care management services and bill the HH+ rate. The CMA must attest that they are in compliance with all staffing qualifications, case load ratios, and training requirements. CMAs 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:

1. CMA is an Article 28 or Article 31 provider, certified home health agency, community health center, community service program, or other community-based organization with:

    a. Two years' experience in the case management of persons living with HIV or AIDS; OR
    b. Three years' experience providing community-based social services to persons living with HIV or AIDS; OR
    c. 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.

**Care Manager Qualifications and Training**

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

    a. Care Management Supervisor: Minimum qualifications
        i. Master's degree in Health, Human Services, Mental Health, Social Work and one year of supervisory experience and one year of qualifying experience **OR**

        ii. Bachelor's degree in Health, Human Services, Mental Health, Social Work and two years of supervisory experience and three years of qualifying experience**.
    b. Care Manager/Coordinator: Minimum qualifications:
        i. Master's or Bachelor's degree in Health, Human Services, Education, Social Work, Mental Health and one year of qualifying experience **OR**
        ii. Associates 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.
    c. Navigator/Community Health Worker/Peer:
        i. Minimum qualifications o Ability to read, write, and carry out directions **AND**
        ii. High School Diploma or GED, **OR**
        iii. Certified Alcohol and Substance Abuse Counselor (CASAC), **OR**
        iv. Certification as a Peer (AIDS Institute Peer Certification preferred), **OR**
        v. Community Health Worker

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

**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. Training requirements include:

1. All core competency content areas completed within the first 18 months of employment, **AND**
2. A minimum of 40 hours annually thereafter. Refer to *Core Competency Content Areas* resource for the list of **Priority Content Areas** section for the areas of training.
3. Annually the following trainings must be completed:

a. Child abuse and neglect (Mandated Reporting), **and**
b. HIV Disclosure/Confidentiality, **and**
c. The Role of the Health Home Care Manager in Improving Health Outcomes for PLWHA or At-risk of HIV, **and**
d. Sexual Health and Gender Orientation (SOGI)

**Eligible Population**

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**
    a. Had three or more in-patient hospitalizations within the last 12 months; **OR**
    b. Four or more Emergency Room visits within the last 12 months; **OR**
    c. 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;

        i. 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**

        ii. 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**

        i. 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:
            1. Status of an individual's viral load **AND**
            2. 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.

**Care Management for Individuals with HIV**

1. Member who are **not** virally suppressed must be linked and referred to care that leads to the achievement of viral suppression.
    a. Objective and Intervention must be present in the member's plan of care.
    b. Barriers to care related to a member's positive status must be present in the member's plan of care and documentation.
    c. Member's comprehensive assessment must contain specific information regarding the member's barriers to care in areas such as:
        i. Appointment attendance
        ii. Medication adherence

iii. Gaps in HIV knowledge
iv. Housing
v. Food insecurity
vi. Income

2. Virally suppressed (<200 copies per mL) individuals, the viral load and CD4 measures must be monitored no less than every 6 months. It is the responsibility of the CM and CMA Supervisor to ensure the member:
    a. Understands viral suppression/undetectable = untransmittable (U=U).
    b. Understands the importance of adherence to medical appointments
    c. Understands the importance of consistently taking medications as prescribed.
    d. Is aware of upcoming HIV appointments.
    e. Has the necessary supports in place to attend appointments, such as transportation and child care.
3. Co-occurring conditions impacting a member's HIV status must be documented in a member's record.
4. Linkage and retention in care leading to/maintenance of viral suppression is the primary goal of an HIV-positive member.
5. CM must establish a working relationship with the HIV primary care provider
6. Case conferencing with HIV Medical Providers is required **every 6 months**. Case conferences must include:
    a. A member's current treatment regimen,
    b. Any adherence challenges,
    c. Other medical conditions impacting (or impacted by) client's HIV status,
    d. Review of recent viral load,
    e. Needs related to nutrition,
    f. Any member concerns, and
    g. POC issues being addressed by the CM that will impact the member's ability to access HIV care.

**HH+ Caseload Model**

To meet the changing and complex needs of the HH+ population, CMAs may utilize different models of care management to achieve successful transitions, continuity of care, and improved outcomes. CMAs have the option to adopt any of the following models of care management listed below. To ensure HH+ recipients on a given caseload receive the required level of services, the noted case load limits will apply:

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

2. If the program implements a team model with Peers/ Navigators/Community Health Workers, the case load may increase by 5 for each team member. One Care Manager may supervise no more than two team members. Four core services must still be delivered with this model and one must be a face to face with the Care Manager (CM).
    a. One (1) Health Home care manager plus one (1) peer/navigator/community health worker – maximum case load of 25-30 members.
    b. One (1) Health Home care manager plus two (2) peer/navigator/community health worker – maximum case load of 35-40 members.
    c. One care manager may supervise no more than two team members.

3. 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.
    a. One (1) Health Home care manager with ten (10) or more HH+ members – max caseload 40 members (inclusive of HH+ members).

Technical Assistance to Health Homes and Care Management Agencies The AIDS Institute (AI) Health Home team provides Technical Assistance to Health Homes and CMAs, including understanding caseload models. The AI Health Home team can be reached at HIVCareMgt@health.ny.gov.

## COMMUNICATION/TRAINING/IMPLEMENTATION

BCHNHH staff and partnering CMAs serving HH+ members will ensure to check qualifications of each member prior to enrollment. Supervisors and direct care management staff shall possess key skills and knowledge for serving high need individuals with SMI, including but not limited to the following areas:

1. 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).
2. Create and leverage relationships with critical behavioral health service providers to plan and coordinate care management needs for high-need SMI individuals including:

    a. Navigating the mental health service system-including ability to make referrals to mental health housing services, crisis intervention/diversion, peer support services
    b. Knowledge of the behavioral health managed care benefit package and coordinating care with MCOs (e.g. for HARP members)
    c. Collaborates with inpatient staff and MCO (as applicable) to affect successful transitions out of inpatient or institutional settings
    d. Addressing the quality, adequacy, and continuity of services to ensure appropriate support for individuals' mental health and psychosocial needs.

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 but are not limited to :

    a. Motivational Interviewing
    b. Suicide Prevention
    c. Risk Screening
    d. Trauma Informed Care
    e. Person-centered care planning and interventions
    f. Recovery-Oriented Approaches (e.g., Wellness Recovery Action Plans)

The OMH Medicaid case generally remains open for the month of person's discharge and the following month during the transition process. Care managers should confirm that coverage is transitioned to the new Medicaid district.

For most adults age 65 or older who are inpatients in a State PC, OMH (Medicaid District 97) will have opened a Medicaid case. Following discharge, that coverage is transitioned to a local district of NYC HRA.

The OMG Medicaid case generally remains open for the month of the person's discharge and the following month during the transition process. Care managers should confirm that coverage is transitioned to the new Medicaid district.

Once assigned to a CMA, the CMA shall provide immediate delivery of HHCM services, including participation in the pre-release/discharge planning process whenever possible, to support a warm hand-off.

1. For individuals already enrolled in a HH and being discharged from a State PC or CNYPC, the CMA shall participate in the discharge planning process and have a face-to-face contact with the individual within 48 hours of discharge. Current best practice indicates that face to face contact with an individual within 24 hours of release from a forensic facility is pivotal to successful engagement for this population.

2. Coordination of care will likely include the reestablishment of Medicaid benefits for this population, so that individuals have immediate access to all services on their plan of care.

3. For individuals being released from prison with Parole, the health home care manager should establish contact as soon as possible with the Parole Officer to coordinate efforts for helping the individual follow their mental health discharge plan, which will include care management.

## Quality Management & Performance Improvement

BCHNHH will:

1. Review each chart identified as HH+ from CMAs to ensure that the member is qualified for HH+ and assure that the staff assigned to the member is HH+ qualified.

2. Ensure that staff are up to date policy and procedure, resources and trainings.

3. Review at minimum three HH+ charts per month to monitor service quality, if any trends are identified, a training will be implemented and will also be discussed during the QMP monthly meeting. If trends are specific to a CMA, BCHNHH will provide feedback to that agency and assist with needed changes.

4. Provide reports to network CMAs to monitor HH+ enrollment, to ensure members are enrolled no longer than the consecutive 12 month period and that each CMAs roster is accurate.

5. Provide training to HH staff, including network CMAs, related to this policy and procedure.

## RELATED FORMS

- *Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations*
- *Assisted Outpatient Treatment Program: Guidance for AOT Program Operation*
- *Significant Events Related to Assisted Outpatient Treatment (AOT) Court Orders*
- *Core Competency Training Resource*
- *NYSDOH/AIDS Institute Health Home Plus (HH+) Attestation for HIV+ Individuals*
- *HH+ Eligibility Documentation Resource*

- *HH+ Eligibility Crosswalk*
- *Request for Waiver of HH+ SMI and Adult BH HCBS Assessor Qualifications*
- *Definition of Serious Mental Illness for Health Home Eligibility*