



Health Home Plus Program Guidance for Individuals with HIV

Description

Health Home Plus (HH+) is an intensive care management program established to provide HH members 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.¹

The Governor's EtE Initiative and the Health Home Model

In June 2014, the Governor announced his three-part initiative to end the HIV epidemic (EtE) in New York State by the end of 2020. Among the policy and program innovations that have resulted from EtE is the imperative that HIV treatment target viral load suppression as the clinical gold standard for improving the lives of individuals living with HIV and for preventing new viral transmission.

It is also recognized that social and behavioral factors contribute significantly to the inability of HIV+ individuals to remain engaged in the healthcare system and to achieve viral load suppression. This is especially true for individuals with co-occurring conditions of Serious Mental Illness (SMI), Substance Use Disorder (SUD), or homelessness.

The HH+ Program for individuals with HIV is intended to align the 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.

¹ 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.

Eligible Populations:

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 in the 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

3. Clinical Discretion: Managed Care Organizations (MCO)s coordinate physical and behavioral health services for individual members. MCOs – including mainstream plans, HIV-SNPs and HARPs – **and** medical providers are responsible for ensuring that high need members have positive health outcomes and receive needed services. 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.

It is common for individuals who have recently become unsuppressed to need continued intensive support to ensure ongoing suppression; examples include a history of adherence issues, current instability with housing, chaotic substance use, or newly diagnosed status.

Members who are Eligible for AI and OMH Health Home Plus

CMA supervisors and care managers/coordinators should determine the most appropriate HH+ assignment for a member who is diagnosed with 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 health home/care management agency regarding the most appropriate care management program that will best serve the member's needs while also respecting member choice.

The care manager supervisor, care manager, and the member must evaluate what the most pressing concerns are for this member and the root cause of their instability. The Plan of Care should address the dual needs of the member. If the person is virally unsuppressed, the need to work toward adherence to care and treatment (medication) is a priority. If the person's SMI is not controlled, then this too must be a priority. In such cases, supervisory staff must review the needs, review the plan of care, and ensure that the medical and mental health providers are contacted and include the care manager and member in the conversation about what the most appropriate CMA would be. The care manager supervisor must actively work with the care manager to ensure that the needs of the member are being appropriately addressed.

Care Management Agencies (CMAs) Eligible to Serve HH+ Individuals/Provider Qualifications

All legacy COBRA HIV TCMs are eligible to provide HH+ care management services and bill the HH+ rate. The CMA and Lead Health Homes must attest that the CMA is in compliance with all staffing qualifications, case load size guidance, 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:

- 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.

Attestation

Prior to billing for HH+ services, Lead Health Homes are responsible for submitting written attestation of all contracted CMAs who will provide HH+ for members who are HIV+ and meet credentials, staff qualifications, core competencies or annual trainings. Health Homes must have formal policies and procedures in place for ensuring such credentials are current at the time of HH+ service delivery.

Staff Qualifications

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:

- Care Management Supervisor: Minimum qualifications
 - Masters degree in Health, Human Services, Mental Health, Social Work and one year of supervisory experience and one year of qualifying experience; **OR**
 - Bachelors degree in Health, Human Services, Mental Health, Social Work and two years of supervisory experience and three years of qualifying experience**.

- Care Manager/Coordinator: Minimum qualifications
 - Masters or Bachelors degree in Health, Human Services, Education, Social Work, Mental Health and one year of qualifying experience**; **OR**
 - 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**

- 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.

Program Requirements

Program requirements for HH+ members 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

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf.

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.

Case Load Ratio:

- The required caseload ratio for HH+ members shall be one (1) full-time employee to a maximum of 15 HH+ recipients.
- If the program implements a team model (team is defined as one (1) care manager/coordinator and peers/navigators/community health worker), then the case load may increase by 5 for each additional team member.
- One (1) care manager/coordinator may supervise no more than two team members.

Contact Frequency:

- A minimum of four (4) core services must be provided per month
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf
 - At least two (2) of the four (4) core services must be face-to-face contacts.
 - At least one (1) face-to-face contact per month must be with the care manager/coordinator.
- 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).
- Case conference with all providers and the client must occur every six months, or as needed based on the needs of the client.
- If contact frequencies have not been met, then the CMA may bill for core services at the High Risk rate for that month.

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.

Training requirements include:

- Core competency trainings completed within the first 18 months of employment, **AND**
- A minimum of 70 hours annually thereafter.

Core Competency Trainings

Most core competency trainings are offered in multiple formats including in-person, webinar, and online training. Supervisors should use discretion and select the format that best fits the needs of individual staff. In-house trainings (staff meetings, inservice trainings, grand rounds, etc.) may be used for trainings, but must meet the basic elements of the core competency trainings.

Required Core Competency Training

- Child Abuse and Neglect (annual update)
- HIV Disclosure and HIV Confidentiality Law Overview (annual update)
- 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 Approach Overview
- Overview of HIV Infection and AIDS
- Overview of STIs
- LGBT Cultural Competency
- Promoting Primary Care and Treatment Adherence for HIV Positive Individuals
- Role of Non-clinicians in Promoting PrEP
- Sex, Gender, and HIV/STIs
- Ending the Epidemic
- AIDS and Adolescence-The Changing Legal Landscape
- Transgender Health 102- Addressing Barriers to Care
- Improving Healthcare with People Who Use Drugs
- Drug User Health-Caring for the Whole Person

To assist staff in meeting the 70-hour annual requirement, the AIDS Institute provides a comprehensive list of training resources, which can be found at <https://www.hivtrainingny.org/>

Care Management Models That Meet HH+ Requirements

To meet the changing and complex needs of the HH+ population, CMAs may utilize different models of care management to 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.

HH+ only caseload: case load comprised only of individuals with HH+ levels of need

MODEL 1: HH+ with Care Manager Only

- One (1) Health Home care manager/coordinator – maximum case load of 15 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 20 members.
- One (1) Health Home care manager/coordinator plus two (2) peer/navigator/community health worker – maximum case load of 25 members.
- One care manager/coordinator may supervise no more than two team members.

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

Mixed Caseloads: 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 five (5) or more HH+ members – max caseload 25 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 CMA 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.

For technical assistance with caseloads, please contact the NYSDOH AIDS Institute at HIVCareMgt@health.ny.gov

Referral for Health Home Plus

Referrals can come from multiple sources including community providers, behavioral health providers, MCOs, hospitals 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 must ensure the individual is promptly assigned to a CMA qualified to serve the HH+ population.

Billing and Tracking System

The unique rate code for HH+ services is 1853.

HH+ payment rates for Downstate and Upstate are noted in the table below.

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

Monitoring

DOH reserves the right to perform reviews of Health Homes to monitor compliance with the HH+ credential requirements outlined above. DOH and AIDS Institute maintain records of Health Home attestations. DOH will also evaluate performance for generating positive health outcomes for 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. The AI Health Home team can be reached at HIVCareMgt@health.ny.gov.