RI Medicaid

Provider Reference Manual

TARGETED HIV MEDICAID CARE /CASE MANAGEMENT

RHODE ISLAND MEDICAID DIVISION
HIV Provision of Care &
Special Populations Unit

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Areas of Focus:

Targeted Care/Case Management Protocol for People Living with HIV & AIDS

Targeted Case Management Protocol for People at High Risk for HIV

Revision History

Version	Date	Reason for Revisions	Sections Revised
1.0	20 January 2016	New document	
1.0	5 April 2016	Revisions	Community, providers, staff revisions
2.0	1 June 2016	Version 2	Final review of all sections and edits
3.0	3 March 2017	Version 3	Final, final draft for publication

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Section I – Rhode Island Medicaid HIV TCM Provider Manual Outlined

INTRODUCTION TO THIS PROVIDER MANUAL

The Rhode Island Executive Office of Health and Human Services (EOHHS), in conjunction with Hewlett Packard Enterprise Services (HPE), developed provider manuals for all RI Medicaid Providers The purpose of this guide is to assist Medicaid providers with Medicaid policy, coverage information and claim reimbursement for this program. General information is found in the General Guidelines Reference Manual. The HPE Customer Service Help Desk is also available to answer questions not covered in these manuals.

Hewlett Packard Enterprise can be reached by calling:

- 1-401-784-8100 for local and long distance calls
- 1-800-964-6211 for in-state toll calls or border community calls

The Centers for Medicare and Medicaid Services (CMS) has published interim final regulations to govern case management services under Medicaid (Federal Register, December 4, 2007, Vol. 72, No. 232, 68077-68093; 42 CFR Parts 431, 440 and 441). Under these regulations Medicaid case management services are services that will assist individuals in gaining access to needed medical, social, educational or other services. These regulations were promulgated to implement part of the Deficit Reduction Act of 2005 (DRA, Public Law, 109-171—see the Bazelon Center's March 2006 Mental Health Policy Reporter) and are CMS' interpretation of Section 6052, Reforms of Case Management and Targeted Case Management. The rule covers case management services and targeted case management services and seeks to clarify the situations in which payment will and will not be made by Medicaid.

The language above specifically references Medicaid definition of Targeted Case Management. You shall notice that in this document there is a clarification between the terms "Targeted HIV Care Management for People Living with HIV/AIDS" and "Targeted Case Management for People at High Risk for HIV." It is important to acknowledge that while we present two areas, care and case management within this manual, **the terms shall be used interchangeably.**

For specifics regarding the difference in the nature of these terms as they apply to the populations to be served by either function, and for practice details see page 4-5, Scope of Service. For simplicity, we shall refer to **care** management as it applies to people living with HIV, and **case** management to those at high risk for HIV. **Essentially, the practice components are the same, and each area whether it be case or care management must fulfill the Intake, Assessment/Reassessment (Severity Indexing is found here), Care Planning (Care Planning shall be required even for people at high risk for HIV), and Documenting HIV Quality Performance Measures (metrics).**

Case/Care management services are defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case/care management can be furnished without regard to Medicaid's state-wideness or comparability requirements.

The preamble to the CMS regulation clarifies that case management cannot be furnished to an individual who is not yet determined eligible for Medicaid. However, Medicaid administrative costs can include assisting individuals in applying for or obtaining eligibility, re-determinations of eligibility, intake processing, preadmission screening for inpatient care, prior authorization and utilization review, and outreach. States may not claim costs for administrative activities if the activities are an integral part or extension of a direct medical service.

For the purposes of this Provider Manual we seek to more clearly define the allowable expenses and services associated with HIV Targeted Case/Care Management for both fee for service (FFS) and expansion populations. The functions of RI Medicaid HIV Targeted Case/Care Management reimbursed by FFS and expansion must assist persons eligible for Medicaid to access needed medical, social, psychosocial, educational, financial and other services required to encourage the enrollee's maximum, independent functioning in the community. ***Case/Care management provides access to services but does not include the actual provision of the needed services.***

Case/Care Managers providing services within this framework must be well versed in all of the Rhode Island Medicaid benefits for beneficiaries (transportation, home and community health services, etc.), so that they can maximize the full potential of the benefits package for the clients they serve.

RI Medicaid HIV Targeted Case/Care Management (RIMTCM) has the following unique characteristics among Medicaid services:

- It is targeted to people living with HIV/AIDS who will benefit from a focused effort to improve access to a wide range of medical, human and social services;
- A State Medicaid Plan Amendment is prepared by the RI Executive Office of Health & Human Services for each targeted population. Each state plan amendment (SPA) and targeted case management program may be tailored to the needs of the target population. Case/Care Management already exists in the State Plan Amendment;
- RIMTCM Provider entities, are enrolled as Medicaid providers of targeted case/care management for people living with HIV/AIDS and/or for people at high risk for HIV (HIV negative individuals) on the basis of the approved proposal and designation by the statewide supervising authority. *Providers may serve only the population for whom they are designated*; and monthly contact requirements, case/care

manager qualifications, service standards, reimbursement methodology and resulting billing rules may be specific to the approved State Plan Amendment (i.e. target population).

PROVIDER PARTICIPATION GUIDELINES

Qualifications of Provider Entities and Case Managers

Provider Entity Qualifications

Case management services may be provided by social services agencies, facilities, persons and groups possessing the capability to provide such services that are in compliance with the Medicaid provider qualifications.

Prospective providers of HIV case management services may include, but are not limited to:

- Facilities licensed or certified under Rhode Island Law or regulations;
- Health care or social work professionals licensed or certified in accordance with Rhode Island state Law;
- State and local government agencies

The Executive Office of Health & Human Services shall enter into a direct provider agreement with fee for service HIV targeted case management providers. Providers under Medicaid expansion shall have direct provider agreements with the Managed Care Organizations participating in expansion. Providers selected to perform HIV case management for targeted management services must have specific, documented experience working with people living with HIV and/or people who are qualified as high risk, negative individuals.

The following qualification requirements apply to potential providers of TCM:

PROVIDER QUALIFICATIONS: Applications will be accepted from certified home health agencies, community health centers, community service programs, and other community based organizations with:

- At least two years' experience in the case management of persons living with HIV and AIDS; or
- At least three years' experience providing community based social services to persons living with HIV and AIDS; or
- At least three years' experience providing case management or community based social services to women, children and families; people living with behavioral health conditions (substance users, mental health); homeless persons; adolescents;

parolees and other high risk populations, and includes one year HIV related experience.

Case/Care Management Staff Qualifications

Individual case managers must meet the education and experience qualifications listed b e l o w :

STAFF QUALIFICATIONS: To qualify immediately as an eligible Medicaid Targeted Case Manager, upon entry, case managers must have:

- At least one year of case management experience and a college degree in a health or human service field; ***or***
- At least two years of case management experience and an additional year of experience in other activities with the target population and an associate's degree; ***or***
- At least one year of case management experience, a high school diploma, and a case management certification from an accredited institution, and, additionally, at least two years of H I V experience or/ other activities with the target population; ***or***
- A bachelor's or master's degree which includes a practicum encompassing a substantial number of case management activities, including the performance of assessments and development of case management plans.

Within 18 months of entry (not to exceed 18 months) as a case manager:

- All case managers must have a case management certification from a reputable, accredited, college/university. Case managers that do not have a certificate must be closely supervised under an experienced case manager (an experienced case manager with a certificate and the credentialed skills listed above).

OR

- *A minimum of an Associate's Degree from an accredited college or university; and*
- *A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness preferred; and/or*
- *State or National certification from a recognized state/national certification organization and/or licensing organization preferred (i.e. LBSW, LMSW, LCSW, LPC, LMFT, LCDC, etc.,); or*
- *Case managers employed prior to March 1, 2009 and who did not meet the minimum qualifications listed above may be granted a waiver from these qualifications by the Administrative Agency (pending three letters of recommendation from an employer or a supervisor attesting to their length of employment and qualifications to perform HIV case management services) ; and*

- *Knowledge and training in assessment of needs, formulation of care plans, monitoring of care plans and evaluation of case pro files; and*
- *Extensive knowledge of community resources and services.*
- *Each agency staff person who provides direct services to clients shall be properly trained in case management. Supervisors will be a degreed or licensed individual (by the State of RI) in the fields of health, social services, mental health, or a related area, preferably Master's Level.*
- *Ongoing training is required for all case management staff.*
- *At least one year of case management experience and a college degree in a health or human service field; or*

Case Manager Training and Advancement

- **Training:** Qualified providers must insure that all case managers within this discipline are trained accordingly and they must provide ancillary training and updates at least four hours per year (in addition to any case management, continued certification requirements).
- **Advancement:** In the interest of creating a sustainable, equitable and well trained workforce, providers must submit a plan/schedule of advancement for case managers that includes apprenticeship, entry and senior level case management opportunities with pay and responsibilities reflective of these advancements. This plan/schedule should be based upon the credentials of a case manager when entering the TCM system (see above) as well as advancement determined by the agency. For example, a case manager with the least experience and academic credentials may be classified as an apprentice for a limited time so determined by the provider with all the benefits, pay scale associated with this level.

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PROVIDER ENROLLMENT

Providers who wish to enroll with RI Medicaid, should view the instructions in the General Guidelines Reference Manual .

SCOPE OF SERVICES FOR TARGETED HIV CASE/CARE MANAGEMENT

In general, targeted case/care management services consist of the activities listed below. They include an **Intake Process, Assessment/Reassessment (Severity Indexing is found here), Care Plan and Documenting HIV Quality Performance Measures (metrics).** The Medicaid fee for service program has a rate methodology resulting in quarter hour units of service, such that all HIV targeted case management activities use a procedural code to bill for services that are allowable. Case/Care Managers must present allowable items for billing only. ***Expansion providers shall be instructed as to their rate structure and shall work closely with the assigned MCO plans. Prior to performing services for case management contact your Managed Care Organization representatives to receive billing instructions.***

HIV Targeted Case/Care Management Services Outlined

To be eligible for RI Medicaid HIV Targeted Case/Care Management services, enrollees must be Medicaid eligible and a member of one of the following groups:

1. **HIV infected persons;**

2. **HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; or**

3. **Individuals deemed to at 'high risk" for HIV until tested and HIV status is confirmed.** High risk individuals are those individuals who are members of the following populations:

   - Men who have sex with men (MSM),
   - Active substance users and/or those individuals with documented mental illness,
   - Persons who have Hepatitis B or C,
   - Persons with a documented history of sexually transmitted diseases,
   - People recently released from prison and/or the training school (TCM services may be delivered within one year post release),
   - Sex workers,
   - Transgender individuals,
   - Bisexual men and woman,
   - Sexually active adolescents engaging in unprotected sex, or

- Persons who engage in unprotected sex with HIV+ or high risk individuals.

Individuals at High Risk for HIV must be evaluated upon entry via a specific HIV negative, high risk severity assessment. The assessment shall yield a Severity Index for each client.

Specific Targeted Care Management Protocol for People Living with HIV & AIDS, and for Targeted Case Management Protocol for People at High Risk for HIV

Intake Screening

Parameters for enrollee eligibility at the Intake Screening are outlined in the Rhode Island Standards for HIV Case/Care Management. Intake Screening must take **place within 3 days of referral to the program**. Intake procedures are established by the provider agency and must involve specific financial screening tools to confirm Medicaid eligibility, as well as a brief Intake Service Plan must be completed at the time of Intake to address immediate needs (triage of needs), ***general*** severity index and generally outline action steps. This brief Intake Service Plan shall be transferred to the Care Plan. *An enrollee may be enrolled and an intake completed during institutionalization in a hospital or long-term care facility as long as discharge is imminent [within 180 days (per ADA, Olmstead v. L.C.)]. The case manager should actively incorporate Intake into the encounter with the enrollee.* This activity may be different than the agency's specific, more comprehensive process of Intake. Intake shall result in acceptance or denial of the client as an eligible participant in the benefit.

Targeted Care Management Protocol for People Living with HIV & AIDS, and Targeted Case Management Protocol for People at High Risk for HIV

ASSESSMENT AND REASSSESSMENT (SEVERITY INDEX)

Assessment and Referral must take place within 30 days of Intake.

During this process, information about the enrollee and the resources available to the enrollee are gathered to develop a care plan specific to the enrollee's needs. The case/care management process must be initiated by a written assessment of the enrollee's need for case/care management in the areas of medical, social, human services, behavioral health services, psychosocial, educational, financial, and/or other services. This process should include information from the enrollee and, with the enrollee's permission, from any collateral sources whose information is necessary to make a comprehensive assessment.

Assessment provides verification of the enrollee's current functioning and continuing need for services. The following are intrinsic to the Assessment/Reassessment process:

➢ Severity indexing

Is a measurement instrument used to assess a client's level of functioning, severity of illness, poly morbidities, social determinants and other risk factors. It involves questions or probes that evaluate elements like behavioral health (substance use and/or mental illness), homelessness, ability to work, severity of HIV, risk associated with transmitting the HIV virus, risk of getting the virus, etc. *All providers who assume the responsibilities associated with HIV TCM services must use a standardized Severity Index issued by the Executive Office of Health & Human Services.* Creating a solid and usable Severity Index assists both the client and the case/care manager in determining action steps and achievable goals. Severity Indexing is a vital part of Assessment and shall be monitored throughout the Reassessment phase.

➢ Essentially A**ssessment/Reassessment**

Defines the service priorities and provides an evaluation of the enrollee's ability to benefit from such services. A dedicated effort must be documented relating to the client's baseline Severity Index score and specific plans that will address and enable improvement over time. **Goals must be clearly set in the client file that document when and how transitioning can occur from a high state of severity to lower states of severity.**

- **Transitioning Documentation:**
  Also intrinsic to this process of assessment/reassessment is the transitioning from case/care management, when the client no longer requires the service. Upon the enrollee's acceptance of case/care management services, an initial assessment must be completed by a case/care manager within 30 days of referral or within 30 days of the enrollee's acceptance of services.
- **Reassessment:**
  Assessment is a continuous process, which is the result of each encounter with the enrollee and the dialogue between the enrollee and case manager. However, a reassessment of the enrollee's need for case/care management and other services must be completed by the case manager every six months, or earlier if required by changes in the enrollee's condition or circumstances.
- **An evaluation of any functional impairment**
  On the part of the enrollee and, if necessary; a referral for a medical assessment should be made as well as a determination of the enrollee's functional eligibility for services.
- **Review and process information**
  From other agencies/individuals required to identify the barriers to care and existing gaps in service to the enrollee; and,
- **A comprehensive assessment**
  Of the individual's service needs including medical, social, psychosocial, educational, financial and other services. An assessment must be completed on all minor children living in the household and/or those minor children of the index enrollee who are dependent on the enrollee.

Specific Targeted Care Management Protocol for People Living with HIV & AIDS, and Targeted Case Management Protocol for People at High Risk for HIV

CARE PLAN AND DOCUMENTING HIV QUALITY PERFORMANCE MEASURES AND OTHER CRTICAL INFORMATION

After all of the preceding elements occur a detailed process of enrollee/client engagement begins. Often this is described as the case/care management planning and coordination stage, and the **Care Plan** is officially engaged. The case/care manager, with the enrollee, identifies the course of action to be followed, the informal and formal resources that can be used to provide services, and the frequency, duration and amount of service(s) that will satisfy the enrollee's need.

It is highly recommended that an initial assessment of need be done prior to the care plan. Crisis management (see Crisis Management description below) may be employed at this point and that is to be documented in the Care Plan. For example, if a client is homeless it is understood that many factors of success for their health outcomes rely on finding a safe, home. The Care Plan can be initial in nature if crisis presents when a client is first enrolled. An initial, written care plan must be completed by the case manager for each enrollee at the time of the Assessment. A complete care plan must be written within 30 days after the date of assessment.

The **Care Plan** includes, but is not limited to, the following activities:

- **Identification of the nature, amount, frequency, duration and cost of the case management services** to a particular enrollee;
- **Severity Index monitoring: (Severity indexing can be documented in the initial assessment as a baseline measure associated with client needs. Severity indexing must always be clearly documented in the care plan. Severity will change over time and must be monitored according to the circumstances.)**
- **Selection of the services** to be provided to the enrollee, with specific evidence that a referral was made (whenever possible action steps associated with referrals is requested, and if upon subsequent visits ;
- **Identification of the enrollee's informal support network and providers** of services;
- **Specification of the long term and short term objectives** to be achieved through the case management process;
- **A primary program goal**, such as self-sufficiency, must be chosen for each enrollee of

targeted case/care management. Additionally, the enrollee's personal goal for the coming year should be specified. Intermediate objectives leading toward these goals and tasks required for the enrollee to achieve a stated goal should be identified in the plan with the time period within which the objectives and tasks are to be attained.

- **Performance Measures: <u>If the person is living with HIV/AIDS</u> specific documentation of performance measures** across the HIV Continuum of Care must be initially documented (Baseline) and followed throughout the reassessment phase (every six months). Some elements we shall expect to be documented and reported upon are 1) Documentation that reveals the enrollee is in care and receiving medical treatment for HIV, 2) Evidence that the enrollee has been offered Antiretroviral Medications (ARVs), 3) Document ARVs and other medications, 4) Document viral suppression using laboratory test confirmation, 5) Document that enrollee visits the medical care provider at least twice per year, 5) Document if the enrollee drops out of care, is taking ARVs, and is not virally suppressed. **(See specific metrics/performance measures framework below).**

  <u>For People at High Risk for HIV</u> a series of performance measures relating to referrals (e.g., behavioral health services, medical visits, housing, etc.), HIV Testing, STI testing, Vaccinations, other testing, outcomes associated with diversion from emergency room visits, hospitalization, housing, incarceration, sexually transmitted infectious disease documentation, etc. must be initially documented (Baseline) and followed throughout the reassessment phase (every six months). **(See specific metrics/performance measures framework below).**

Specific Targeted Care Management Protocol for People Living with HIV & AIDS, and Targeted Case Management Protocol for People at High Risk for HIV Evaluation

METRICS REPORTING FRAMEWORK

Why Metrics and Performance Measures?

For both people living with HIV as well as people at risk for HIV, we seek to measure specific events and outcomes. ***We seek to establish two phases of measurements (metrics) each year.*** The first phase of metric collection can be achieved at Intake or upon Assessment (baseline shall be established for all clients and so noted upon data collection) and the second phase is six months thereafter for post measures. The purpose of developing and collecting metrics is related to documenting performance measures for people living with HIV is to monitor the progress of the client in care management. For this population we seek performance measures across the HIV Continuum of Care as well as other indicators of success/failure.

Expected and Required Metrics

1. Beneficiary/Patient Participation Measures

- Newly identified HIV+ enrolled in case management (less than 1 year diagnosis; specific date of diagnosis)
- HIV + beneficiaries that are not enrolled in case management
- HIV+ adults who were lost to HIV medical care greater than 1 year specify when loss to care and re-engagement occurred
- HIV- , high risk enrolled in case management
- HIV-, high risk not enrolled in case management

2. **Beneficiary/Patient Process Measures**

- HIV + and HIV - : Unduplicated HIV tests/results for negative and positive tests (date of test and number of tests per year)
- Newly diagnosed HIV+ adults who are identified through HIV screening
- Newly identified HIV+ adults linked to HIV medical care
- HIV + : Months from first HIV+ test to linkage to care for newly diagnosed HIV+
- HIV + : Three- and six-month retention rates of HIV+ adults at baseline and after linkage, twice per year
- HIV + and HIV - : Newly identified/recurring STIs, HBV and HCV screen, HBV other Immunizations
- Acuity/Severity Index of HIV- and HIV+ enrollees

Please note once a patient is deemed HIV +, laboratory measures on file with clinical documentation is necessary.

3. **Quality of Care Measures**

- HIV+ adults who completed two or more medical visits
- HIV+ adults prescribed ART
  - HIV - : **Document baseline during Intake and Assessment**; 6 month and 1 year post in Care Plan. Note significant components: behavioral health services, medical visits, housing,

emergency room visits, hospitalization, incarceration, sexually transmitted infectious disease documentation, etc. For HIV- , case management is dependent upon need and severity of client situation. To repeat, all events pertaining to metrics must be documented in Care Plan every 6 months.

4. Beneficiary/Patient Outcome Measures

- HIV + : Baseline and six month trends in ART outcomes, as measured by longitudinal changes in viral suppression (viral load labs provide this measure)
- HIV + and HIV - : Adherence to Quality Management performance measures
    - Track linkage to care (HIV-: primary care, etc. for HIV+: Linkage to an HIV provider, PCP, etc.)
    - Track retention in care (For HIV +: Two visits per year, two viral loads per year)
    - For HIV+: On ART, viral suppression
    - For HIV+: Out of Care event documented (date, reason, etc.) and Re-engagement documented
- Documentation for non-medical (Social/human services events) management for HIV+ and HIV- enrollees

➢ **For HIV Negative, High Risk Enrollees:** This population of enrollees must be referred to providers that offer consistent HIV, HBV, HCV and STI testing, and/or other services deemed critical to potentially prevent disease, and/or enhance the beneficiaries' health outcomes. Monitoring risk behaviors and assuring the enrollee in this category receives follow up services directly related to the care plan, identified factors that put them at risk for HIV, and other issues related to high risk categorization, must be specifically addressed.

➢ **For People Living with HIV and HIV, High Risk Negatives** : Collaboration with social services, health care providers and other formal and informal service providers, including discharge planners and others as appropriate. ***This may occur through case conferences or other means and is intended to encourage exchange of clinical information and to assure:***

- ➢ Integration of all clinical care plans throughout the case management process;
- ➢ Continuity of service;
- ➢ Avoidance of duplication of service (including case management services); and
- ➢ Establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the enrollee.
- ➢ For enrollees temporarily hospitalized in acute care general hospitals, case

management should concentrate on the needs of the enrollee once discharged from the hospital. It should not duplicate the efforts of the hospital social service worker or discharge planner, but should concentrate on implementing and monitoring the plan for the enrollee. The case manager should meet with the hospital social service worker and/or discharge planner to review their recommendations, medical orders and follow- up care and to advise them of plans for ongoing case management of the enrollee.

The Care Management Plan must be reviewed and updated by the case manager as required by changes in the enrollee's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the care management plan is reviewed, the objectives established in the initial case management plan must be maintained or revised, and/or new objectives and new time frames established with the participation of the enrollee.

Those activities which the enrollee or the case/care manager is expected to undertake within a given period of time toward the accomplishment of each case management objective follow:

- The name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- The type of program or service providers to which the individual will be referred;
- Those activities to be performed by a service provider or other professionals to achieve the client/ patient related objectives; and
- The type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.
- Note: The above elements are to be documented in the client/patient's file.

Summary of Care Plan

The care management plan may have been referred to as the case management plan previously. The details of the care management plan are relatable to the management of **people at risk for HIV (HIV-)** and elements of the care plan will be used interchangeably for people living with HIV and those at high risk for HIV. In this document the case/care management plan is called a **Care Plan**, and should be completed by the case manager for each enrollee **(HIV+, HIV-).** It is highly recommended that an initial (this may be partial if the case/care manager is unable to verify information or facts, and/or if an emergent issue takes precedent over a series of action items. For example, if a client is homeless and many factors of success rely on finding a safe, home; then the care plan can be initial in nature) written care plan must be completed by the case manager for each enrollee at the time of the Assessment. A complete care plan must be written within 30 days of the date of assessment. It must be

signed by the enrollee to indicate that the enrollee has agreed to the plan. It should include information on needs of those collaterals/family members/children who have a direct bearing on the enrollee's ability to adhere to care and treatment. A copy of the plan must be offered to the enrollee.

For any enrollee in an institutional setting (nursing home, drug rehabilitation, or supportive housing) a joint treatment plan must be developed specifying why the enrollee is being "jointly case managed", what case/care management needs are being addressed and by whom, and the goal to move toward case closure and/or transitional plans. (E.g. The clients is transitioning from a nursing home to the community).

Implementation of the Care Management Plan

Implementation ***means marshalling available resources to translate the plan into action.***

This includes:

- Becoming knowledgeable about community resources, including the various entitlement programs and the extent to which these programs are capable of meeting enrollee needs;
- Working with various community and human services programs to determine which tasks/functions of the care plan will be carried out by the case manager and which by other community and human services agencies. This activity may involve negotiating functions. The case manager is responsible for service/program coordination;
- Securing the services determined in the care management plan to be appropriate for a particular enrollee, through referral to those agencies or persons who are capable of providing the identified services;
- Assisting the enrollee with referral and/or application forms required for the acquisition of services;
- Advocating with all providers of service when necessary to obtain/maintain fulfillment of the enrollee's service needs; and
- Developing alternative services to assure continuity in the event of service disruption.

Case Management Conferences are required at reassessment and also as needed to implement the service plan. Service plans should be amended/updated as the status of the enrollee/family changes and as new needs become apparent.

Those client/patient's with ongoing mental health and/or substance use issues may need more intensive case management to redirect the care plan and to address specific barriers and complex issues that impact the client/ patient's ability to adhere to care and treatment.

Crisis Intervention

- It is recommended that all case managers be trained in crisis intervention.

A case/care manager may be required to coordinate case management and other services in the event of a crisis. Crisis intervention includes:

- Assessment of the nature of the enrollee's presenting circumstances;
- Determination of the enrollee's emergency service needs;
- Securing the services to meet the emergency needs;
- Revision of the care management plan, including any changes in activities or objectives required to achieve the established goal.

Emergency services are defined as those services required to alleviate or eliminate a crisis.

Monitoring and Follow-Up of Case Management Services

Monitoring the acquisition/provision of service and following up with enrollees guarantees continuity of service. Monitoring and follow-up includes:

- Verifying that quality services, as identified in the case management plan, are being received by the enrollee and are being delivered by providers in a cost conscious manner;
- Assuring that the enrollee is adhering to the case management plan and ascertaining the reason for the decision not to follow the agreed upon plan;
- Ascertaining the enrollee's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by another practitioner;
- Collecting data and documenting in the case record the progress of the enrollee (this includes documenting contacts made to or on behalf of the enrollee);
- Making necessary revisions to the case management plan;
- Making alternate arrangements when services have been denied or are unavailable to the enrollee; and

- Assisting the enrollee and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

Enrollee contact and monitoring are expected to be frequent and proactive to ensure the enrollee achieves goals defined in the Service Plan.

Counseling and Exit Planning

The counseling referred to in case management is that which is provided to a TCM enrollee enabling him/her to cooperate with the case manager in carrying out the objectives and tasks required to achieve the goal of TCM services. It is **not** the provision of an actual service such as employment counseling.

Counseling as a function of case management includes:

- Assuring that the enrollee obtains, on an ongoing basis, the maximum benefit from the services received;
- Developing support groups for the enrollee, the family and informal providers of services;
- Mediating among the enrollee, the family network and/or other informal providers of services to resolve problems with service provision;
- Facilitating access to other appropriate care if and when eligibility for the targeted services ceases; and
- Assisting enrollees to anticipate the difficulties which may be encountered subsequent to admission to or discharge from facilities or other programs including case management.

Section II - Requirements for Participation in Medicaid

Participants in the case management services offered by RI Medicaid must be Medicaid beneficiaries for either fee for service or Medicaid expansion. Some characteristics of the system associated with billing are important to consider:

(1) RI Medicaid will link one provider of case management services to one enrollee;

(2) Providers must assure that the enrollee is an appropriate member of the target population and

(3) Providers must assure the enrollee has freely chosen to participate in a

particular case management program.

The effective date of registration/authorization may be retroactive to the date on which the enrollee accepts case management services (as long as this date does not precede the date of the provider's enrollment in the Medicaid Program). In general, initial registration for case management can occur while a enrollee is residing in the community or when discharge from an acute care general hospital is imminent. For institutionalized enrollees (i.e. settings other than acute care general hospitals), the initial registration date must be after the institution discharge. When a Medicaid eligible individual is referred to the case management provider, whether by an agency or by self-referral, the individual has free choice to accept services from that case management provider, to seek services from any other approved case management provider or to reject case management services.

- If the individual decides to change providers, the registration/ authorization will be changed to the new provider, effective the first day of the following month. The first provider will no longer be able to bill for services, which might be rendered to that individual after the effective date of the change. In this situation the care management plan shall be transitioned to the new provider with the knowledge of, and consent of the beneficiary.

Case Management services must not duplicate case management services that are provided under any program, including the Medicaid Program. Since case management/coordination services may be a component of a Federal Home and Community Based Services (HCBS) waiver program, *individuals who are participating in an HCBS waiver program that includes case management/service coordination are* ***not eligible*** *to participate in the HIV case management program.* If an individual is participating in such an HCBS waiver they may choose to be is dis-enrolled from the waiver and enrolled instead in the HIV case management program.

Record Keeping Requirements

A separate, tabbed case record must be maintained for each enrollee (Medicaid beneficiary) served and for whom reimbursement is claimed.

Intake/Eligibility Record Keeping

- the enrollee characteristics which constitute program eligibility;
- a notation of program information given to the enrollee at intake;
- the date and manner of the enrollee's voluntary acceptance of HIV case management services;

Assessment Record Keeping

- the initial enrollee assessment and any reassessments done since that time;
- An initial designation of client acuity/severity;
- Documentation of the initial care management plan and subsequent updates, containing goals, objectives, timeframes, etc. as agreed to by the enrollee and the case manager; progress notes are to be included in the Assessment;
- a statement on the part of the enrollee of the acceptance of case management services;

- copies of any releases of information signed by the enrollee;
- past/present written referrals made;
- correspondence, and a record of enrollee, and
- collateral contacts.

Care Plan Record Keeping

Care Plans are an essential part of the overall management associated with client care. The RI HIV TCM care plan template can be used to organize the plan. It allows the listing of the identified needs, responsible party, linkages to be made etc. A completed sample can be found in the Care Management Plan Appendix to this Manual. This Appendix offers a template and an outline of the components necessary to develop, maintain and review a HIV TCM Care Plan. Please follow those guidelines in the template, and also note:

The TCM care plan is a client centered health and social services plan that details the client's needs and goals and documents an action plan to achieve these goals. The identified needs in the plan are based on the findings from the assessment and the Acuity Scale.
The TCM service plan provides the basis from which the case manager and the client work to address the client's needs.

TCM service plans are intended to facilitate optimal health outcomes, therefore metrics and performance measures are an integral portion of the care plan, so that tracking progress/failure is well documented and reported to the state.

Process Record Keeping

In developing the plan the case manager should use a "SMART" approach so as to monitor and document the process.

Specific: Identified deficiencies during assessment should be addressed one by one. Every issue identified needs a specific objective and activities for direct intervention. Issues should not be grouped. Specific means that the objective is concrete, detailed, focused, well-defined, and straightforward, emphasizes action and clearly communicates what the medical case manager and the client wants to happen.

Measurable: The TCM care plan should have measurable outcomes. If the objective is measurable, it means that the measurement source is identified and medical case manager will be able to track the results of his/her actions and/or interventions and track the progress towards achieving the objective. Measurement is the standard used for comparison. Measurement allows one to know when the objective has been achieved. An important "measure" involved in the care plan is the severity/acuity index.

Achievable/Attainable: The objectives need to be achievable. If the objective is too far in the future, when a client thinks the goal is too ambitious, he/she will find it difficult to keep motivated and strive towards its attainment. When the goal seems too unreachable, clients become frustrated and lose motivation. Little increments could be made as reassessments are done. For example, when a client has been abusing alcohol for many years it will be unattainable to stop using alcohol completely in a week. Here we suggest using Motivational Interviewing and/or Stages of Change to isolate concerns/problem areas/behavior change aspirations, and work towards achievable/attainable, realistic objectives.

[**References related to creating achievable/attainable objectives -**The following references are meant to guide case managers in developing skills and a toolbox approach to creating achievable/attainable objectives for their client's care plan:

Motivational Interviewing (MI) References:
http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf,
http://www.ncbi.nlm.nih.gov/books/NBK64964/,
http://www.motivationalinterview.net/clinical/whatismi.html

Stages Of Change References:
http://peer.hdwg.org/sites/default/files/3b%20StagesOfChangeVersion2-PeerRole-Peer_Training.pdf,
http://www.stepupprogram.org/docs/handouts/STEPUP_Stages_of_Change.pdf]

Result-oriented/Realistic: The client is involved in the planning and development of the TCM care plan and should understand his/her abilities and limitations. The case manager should take into consideration whether the objective is realistic given available resources, skills, and time to support the tasks required to achieve the objective. Using MI and/or

Stages of Change may help here as well.

Time-limited: For effective implementation of intervention a clear timeframe for evaluation is required. Shorter time frames and deadlines will ensure that objectives are followed up actively. Failure of the case manager to set a deadline might reduce the motivation and urgency required to execute the tasks. Deadlines create the necessary urgency and prompt action.

More Care Plan Record Keeping

- The case manager should contact the client within five working days after the development of the TCM care plan to begin implementation of the plan.
- The case manager should develop a TCM care plan with the active participation of the client. It should describe the recommended interventions for at least three barriers to care identified during assessment.
- The TCM care plan should include at least one goal and objective of treatment adherence to help client achieve or maintain suppressed viral load if the client is on anti-retroviral treatment. Following all of the contemporary HIV Continuum of Care performance measures is advised.

Examples of Elements within a Care Plan

- Plans for communication with the client's primary medical team and an identified mechanism of feedback to ensure adherence;
- Documentation of laboratory results and documented (lab reports) viral load and other relevant lab reports recommended by the physician;
- Strategies to optimize adherence and assist with disclosure of HIV status for social support;
- Plans for minimize competing needs, such as obtaining housing, access to social services and transport; A housing plan, if needed, should be incorporated into the TCM service plan;
- Case management programs are expected to assist clients in need of housing to develop housing plan and make appropriate referrals to housing opportunities available in the community;
- Client education on relevant topics, e.g., management of medication side effects, general health literacy;
- Linkages to prevention with positives programs, needle exchange programs and plans for co-management for mental health and substance abuse clients.

The TCM service plan template can be used to organize the plan. It allows the listing of the identified needs, responsible party, linkages to be made etc. A completed sample can be found in the Appendix.

The **case record entries associated with the Assessment and care plan, which record the enrollee and collateral contacts** must contain at a minimum:

- the date of service,
- name of the enrollee or other contact,
- place of service,
- the nature and extent of the service provided,
- name of the provider agency and person providing the service,
- All associated metrics, quality management performance measures, and key data outputs related to the HIV Continuum of Care, and,
- a statement of how the service supports the enrollee or advances a particular task, objective or goal described in the care management plan.
- document the current (post the initial assessment) client severity/acuity index

Other Required Records

The provider of case management services shall maintain other records to support the basis for approval or payment for the case management program, including but not limited to:

- referral agreements,
- provider agreements,
- work plans,
- records of costs incurred in providing services,
- employment and personnel records which show staff qualifications, and,
- time worked, statistical records of services provided and any other records required as a result of any agreements

All records must be maintained for at least six years after the service is rendered or six years after the enrollee's 18th birthday, whichever is later.

Section III - Basis of Payment for Services Provided

Payment for case management services will be made through the Medicaid Program's fiscal agent. Payment will be enrollee specific and available only for Medicaid eligible members of the target population. **Payment will be negotiated via provider agreements rates for Medicaid expansion.**

> **Note: Please note that the MCO expansion rate structure is set with each provider by the participating plans.**

Section IV – Billable (Allowable) and Non-

Billable (Non-Allowable) Services

Certain activities, which are necessary to the provision of case management services, cannot be billed as a service.

Billable (Allowable) Activities

- Documentation of care plans and assessments are billable as their own services;
- Phone calls are allowable given that they occur while providing a case management (service in support of the execution of a care plan or assessment) and they follow the unit structure described above;
- Case recording, monitoring and re-assessing acuity/severity, completion of progress notes, monitoring of quality performance measures, and other administrative reports;
- Training workshops and conferences not to exceed four total hours per year;
- For enrollees who are temporarily hospitalized/ institutionalized for a period anticipated to be **over 30 days**, it is expected that there would be no Medicaid billing for the period of the hospitalization/ institutionalization. *When the admission is initially expected to last **30 days or less**, the case manager/enrollee relationship may be continued, and Medicaid billing is allowed only for HIV TCM services provided in the first 30 days of hospitalization. The basis for the initial expectation should be documented in the HIV TCM record for audit purposes.*

Non-Billable (Non-Allowable) Activities

The following activities are considered a necessary part of a case management program and may be included in the development of the rate methodology (unit cost structure), **but may not be billed for separately:**

- Supervisory conferences, meetings unless specifically for the purpose of advancing the case or making changes to the enrollee's case management plan;
- Intake and screening activities for Medicaid enrollees who while meeting program participation criteria do not accept services;
- Administrative work, including interagency liaison and community resource development related to serving enrollee;
- Pre-discharge TCM engagement activities for enrollees in institutional settings other than acute care general hospitals;

Certain other activities, while they may be closely related to case management, or necessary to the achievement of the enrollee's case management goals and objectives, are not included in the definition of case management services and, therefore, may not be either billed or funded through the rate methodology. These activities are:

- Outreach to non-eligible populations when the enrollee does not accept case management services;
- Enrollee transportation;
- Employment counseling;
- Drug and alcohol counseling;
- Discharge planning;
- Social work treatment;
- Preparation and mailing of general mailings, flyers, and newsletters;
- Child care;
- Medical Assistance eligibility determinations, redeterminations, intake processing and prioritization;
- Nursing supervision;
- Fiduciary activities related to the TCM enrollee's personal funds;
- Any other activity which constitutes or is part of another Medicaid or non-Medicaid service.

Note on Transportation: *It may be necessary for a case manager to escort an enrollee to a service provider in order to help them negotiate and obtain services specified in the enrollee's care management plan. At the same time, the case manager should be encouraging the enrollee's maximum independent functioning in the community. If this exception is justified then,*

- The ongoing need to escort the enrollee should be well documented in the enrollee's case record.

Furthermore, if the case manager is escorting the enrollee to medical appointments or services, the case management should document in the case why the enrollee was unable to obtain needed medical transportation services from Medicaid. In these instances, enrollee transportation may be a billable case management activity.

See attached HIV Care/Case Management Tool Box which includes the following specific forms and instructions related to:

Intake Form
Assessment Form
Acuity Index
Care Plan Template

Section V - Definitions

For the purposes of the Medicaid program and as used in this manual, the following terms are defined to mean:

Active

Active means that the enrollee who is enrolled in intensive case management is seen in face-to-face contacts at least four times a month.

Care/ case Management

Care/Case management is used interchangeably so as to describe a process, which assists persons to access necessary services in accordance with goals contained in a written case management plan. It is important to note this manual focuses upon Targeted Case Management which is not a medical case management service. Rhode Island Medicaid continues to support medical case managers and they are found within clinical settings for a variety of categorical conditions.

Engagement

Engagement means that the case manager is working with the enrollee to determine viability to become an active enrollee.

Enrolled

If an enrollee is enrolled in case management, then the enrollee has been selected from a roster to be serviced by the case manager.

###Document end

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