New York State Department of Health
AIDS Institute

COBRA Community Follow-up Program (CFP)

Request for Qualifications
Program Guidance

Revised February 2010

TABLE OF CONTENTS

		Page
I.	Introduction	3
II.	Need and Intent	3
III.	Provider Qualifications	4
IV.	Program Design Requirements	5
	A. Client Eligibility	5
	B. CFP Staffing Structure	6
	C. Training	11
	D. Contact Frequencies	13
	E. Client Caseloads	15
V.	Service Delivery – Requirements	15
	A. Comprehensive Medicaid Case Management (CMCM) Regulations	15
	B. AIDS Institute Program Standards	15
	C. Documentation	16
	D. Crisis Intervention	17
	E. Freedom of Choice and Client Consent	18
	F. Client Confidentiality	18
	G. Social Services Department Registration	18
	H. Agency Location	19
	I. Insurance	19
VI.	Quality Assurance – Requirements	19
	A. Agency Quality Assurance	19
	B. Agency Reporting	20
	C. NYS Department of Health AIDS Institute Monitoring	20
VII.	Community Follow-Up Program – Billing	21
	A. Comprehensive Medicaid Case Management Activities	21
	B. Billing for CMCM Services	25
	C. Billing/Revenues/Expenses	25
VIII.	Budget	26
IX.	Submissions to the AIDS Institute	28

I. Introduction

The AIDS Institute is seeking applicants to enter into provider agreements with the New York State Department of Health to provide intensive, family-centered case management services, to HIV-infected and high risk persons, who are identified as having had difficulty accessing medical care and/or other services; and who require frequent personal contacts and/or home visitation to ensure their return for medical care and other needed services. Eligible agencies that meet the provider qualifications and hire case management staff qualified under this program will receive Medicaid reimbursement for case management services through direct billing to the Medicaid Management Information System (MMIS). Billing is based on a standardized hourly rate determined by the AIDS Institute and approved by the State Division of the Budget.

All approved providers will be required to sign a Sponsorship Agreement with the State Department of Health, AIDS Institute. Programs will be approved for an initial period of one year. Upon satisfactory performance of activities during the first year, programs subsequently may be approved for additional one year periods. Notice of Intent to apply will be accepted from eligible applicants in all counties of New York State.

II. Need and Intent

New York State remains the jurisdiction most heavily impacted by the HIV/AIDS Epidemic. By Year End 2007, 180,674 AIDS cases have been diagnosed and reported in New York State. An additional 42,396 individuals have been diagnosed as HIV-infected from June 1, 2000, the date on which HIV-Named Reporting was initiated, through 2007. These figures result in 119,929 individuals living with HIV(not AIDS) or AIDS on December 31, 2007, or 25.5% of US PLWHAs (Persons Living with HIV/AIDS).

Through December 2007, over 2,358 AIDS cases in children under the age of 13 have been reported in New York State. Yet only 88 children have been diagnosed in the six years between 2001 and 2007. By Calendar Year 2007, the most recent year for which data is available, the HIV perinatal transmission rate was 1.4% with only 8 children born HIV-infected during that year.

A greater proportion of New York's cumulative (total) adult/adolescent AIDS cases, as compared to the cumulative cases in the United States, are among people of color (75.1% vs. 59.1%); injection drug users (37.0% vs. 28.2%); and women (25.9% vs. 19.6%).

The HIV epidemic has long had a disproportionate impact on New York's communities of color. Among the AIDS cases diagnosed January to December 2007, 93.7% percent were among people of color: African-Americans at 48.1%; Hispanics at 30.2%; Asian/Pacific Islanders at 1.8%; Native Americans at 0.2% and persons of 2 or more races at 2.1%. The case rates per 100,000 population for the same time period are 69.2, 40.9, 4.8, and 12.5 for Blacks, Hispanics, Asians and Pacific Islanders, and Native Americans respectively. These figures compare to Whites newly diagnosed with AIDS during Calendar Year 2007 at 17.5% of new diagnoses and a case rate of 17.5/100,000 population.

A similar pattern is found among Late Testers, individuals diagnosed with AIDS *simultaneously* or *within one year* of their initial positive HIV test. Late Testers, by definition, have lived an estimated one to ten years without knowledge of their HIV-positive status – and infectivity. For Calendar Year 2007, the proportion of Late Testers among all testers by race/ethnicity were: White 30.0%, Black 36.6%, Hispanic 43.2%, Asian/Pacific Islanders at 41.6%; Native Americans at 66.7% and persons of 2 or more races at 39.6%.

While much has been accomplished in NYS, these data indicate that any number of personal, familial, cultural and/or structural barriers continue to come between the individual and needed HIV education, testing, prevention, supportive services, and care.

The complex issues associated with HIV/AIDS require a comprehensive and coordinated approach to care, which can be accomplished through case management. Case management plays a meaningful role in ensuring early intervention for persons with HIV/AIDS who face barriers to receipt of medical care and social services. It represents a single point of entry into a loosely coordinated network of HIV care providers, promoting continuity of care.

Case management is a multi-step process which fosters access to and the coordination of a range of services. The case manager works with the client to assess strengths and identify needed services, assists the client in developing a service plan to meet those needs, helps to arrange access to these services, acts as a client and systems advocate, monitors progress in obtaining these services and makes necessary adjustments to the service plan as resources and needs change over time.

In 1981, the U.S. Congress, recognizing the value of case management services, amended the Social Security Act to authorize Medicaid coverage of case management services to ensure that recipients were assisted in making necessary decisions about the care they needed and in locating providers appropriate to their needs. Section 9508 of the Consolidated Omnibus Budget Reconciliation Act **(COBRA)** of 1985 amended the Act which now:

- provides that a state may elect to furnish case management services as a service covered under the state plan to any specific group (targeted case management);
- defines case management services as services which will assist individuals, eligible under the state plan, to gain access to needed medical, social, educational and other services; and
- specifies that there be no restriction on a recipient's free choice of providers.

This Comprehensive Medicaid Case Management (CMCM) initiative allows states to access state and federal money to implement targeted initiatives to serve special populations that have not been served or are underserved, and are unable to obtain necessary medical or social services unless access to the delivery system is managed for them.

The NYS Department of Health AIDS Institute's targeted CMCM effort is called the COBRA Community Follow-up Program (CFP). Its purpose is to enhance the availability of comprehensive community based, family-centered case management for Medicaid eligible persons with HIV/AIDS. The program's expected outcome is to improve access to the full range

of health and supportive services needed by persons with HIV/AIDS and their families, and increase advocacy on their behalf by making "the system" more responsive to their needs; resulting in improved self-sufficient functioning and the ability to attain or maintain self-support in the community. Additionally, the CFP has established standards of case management which help to ensure that services achieve a defined quality of care.

The persons targeted by the Community Follow-up Program face enormous barriers to care, such as poverty, drug and alcohol use, homelessness, domestic violence, mistrust of medical care and other service providers, fear of losing children to foster care, fear of HIV infection and its consequences, lack of transportation and day care services, and lack of support in accessing care for children, sex partners and/or co residents. These barriers to care require frequent contact, home visitation and community based follow-up made possible by this intensive case management program. Additionally, since many of the barriers to care are often symptomatic of a poorly functioning family unit, the CFP encourages a family-centered approach that includes the case management of family members, co-residents and collaterals involved in the daily functioning of the target client. This approach allows the case management team to arrange for needed services such as day care for infants, drug treatment services for sex partners, or HIV counseling and testing for co-residents when applicable.

III. Provider Qualifications

Applications will be accepted from Article 28 providers, certified home health agencies, community health centers, community service programs, and other community based organizations with:

- two years experience in the case management of persons living with HIV and AIDS; OR
- three years experience providing community based social services to persons living with HIV and AIDS; OR
- three years experience providing case management or community based social services to women, children and families; substance users; MICA clients; homeless persons; adolescents; parolees and other high risk populations, and includes one year HIV related experience.

IV. Program Design Requirements

A. Client Eligibility

The targeted index client must be Medicaid eligible and a member of one of the following groups:

1. Individual living with HIV/AIDS
2. Pregnant and post partum women living with HIV/AIDS, including those who deliver without pre-natal care
3. Infants up to the age of three years old, born to a mother living with HIV/AIDS

4. Family members and co-residents of the above targeted index clients may also receive case management assistance as necessary, to allow for the provision of necessary care and services to the targeted individual. Case management services for collaterals will be limited to issues that directly affect the care of and services to the primary client. If the collateral/family member meets the eligibility criteria of the target population and are Medicaid eligible, and are in need of case management services, they will be enrolled as a discreet client. They will, however be treated as one family unit.
5. High risk individuals (men who have sex with men [MSM], substance abusers, persons with a history of sexually transmitted diseases, sex workers, bi-sexual individuals, sexually active adolescents engaging in unprotected sex, and persons who engage in unprotected sex with HIV+ or high risk individuals) for a temporary period of time not to exceed 6 months. If the individuals test HIV negative, they will be transitioned to other appropriate services.
6. The number of eligible clients at high risk for HIV infection, accepted for case management service, may not exceed ten percent of the total active client caseload.
7. It is the AIDS Institute's policy that referrals and advocacy for HIV counseling, testing and education be included in the service plan of all high risk clients. Clients found to be HIV positive may continue in the CFP. A client who tests negative or after six months remains unwilling to be tested should be referred to another case management program or other appropriate service providers.

B. CFP Staffing Structure

The Team Model

The CFP utilizes a team approach to case management. The use of a multi-level team supports the time, intensity and flexibility needed to provide comprehensive family-centered case management as well as the required community based follow-up which includes home visitation, establishing and maintaining contact with hard to reach families, and agency advocacy. The "team model" promotes more effective and efficient case management. Members of a “team” may vary, and can include various combinations of Case Managers, Case Manager Technicians, and Community Follow-up Workers, with the support and direction of Clinical Case Manager/Supervisors and Treatment Adherence Case Managers. Team compositions should respond to the case management and clinical needs of clients, and meet AIDS Institute case management standards. In addition, team compositions must meet the following CFP expectations:

Clinical Expectations

- Comprehensive Psycho-social and Clinical Assessment – assess, evaluate and identify clients’:
    - Connection to primary HIV medical care, readiness to begin medical care, and ability to remain in care
    - Current and past mental health status, and barriers related to mental health that impede medical care engagement, treatment adherence, and overall stability

    - Current and past substance use, and barriers related to substance use that impede medical care engagement, treatment, and overall stability,
    - Ability to begin and sustain treatment and medical care adherence, and barriers to treatment adherence
    - Current and past housing status, ability to maintain appropriate housing, and system and client-related barriers to accessing and maintaining appropriate housing

- Comprehensive and Client-Specific Service Plan Development – in collaboration with clients, develop a case management Service Plan that includes:
    - Measurable long-term and short-term goals, which are client-specific and based on realistic client, team, and service system resources and abilities. Goal statements should be in direct response to previously identified client needs and barriers to client progress and stability
    - Specific and detailed activities that progressively lead to goal accomplishment
    - Time frames that appropriately correspond to each activity, and lead to goal accomplishment within a timely manner
    - Updated outcomes that detail status and outcome of each activity

- Case Management Team Support – assist case management team through training, technical assistance, and ongoing support in identifying, understanding, and addressing clinical, mental health, and treatment adherence issues more effectively

- Skill Building – work with clients and their families on treatment (medications and medical appointment) adherence issues, and develop strategies and interventions to maximize treatment adherence and understanding

- Health Education/Literacy – provide supportive, short-term counseling/health education/literacy in an effort to assist clients with understanding, cooperating, and adherence to mental health services and treatment

- Crisis Intervention – provide crisis intervention with clients and families when necessary

Case Management Team Expectations

- Client Representation – Case management teams are preferably reflective of client population culturally, linguistically, by region and communities served, and life experiences

- Client Empowerment – enable improved medical and service engagement through peer education, modeling, coaching, and support

- Management of Supportive Services – Access and ensure supportive services to enable client engagement and maintenance in medical care, such as scheduling transportation, translation, and child care services, clarifying treatment plans, and accompanying clients to ensure receipt of services

- Client Engagement – perform regular home visits and client contact to establish trust and rapport with team members and other service providers, and help find and re-engage clients lost to follow-up

- Case Finding – help to build caseloads through targeted community outreach, presentations, and social networking strategies

- Client Advocacy – advocate with medical care and service providers to ensure clients access, maintain, and negotiate service systems

- Team Communication and Coordination – conduct ongoing communication and coordination within the team to regularly update, inform, and direct case management activities, and to ensure all team members are participating equally in the stabilization of clients.

Reimbursement for "team" case management activities is only available for the Clinical Case Manager/Supervisor, Treatment Adherence Case Manager, Case Manager, and the Case Manager Technician positions. However, costs associated with the Community Follow-up Worker are included in the rate reimbursement structure. As a result, there is an expectation that Community Follow-up Workers will be incorporated into team structures in some manner. Peers, Community Health Workers, interns, and other ancillary staff may also fulfill Case Management Team expectations, upon consultation with AIDS Institute program staff.

In considering the team approach the standardized rate structure takes into account the unique requirements of an agency and geographical considerations.

Personnel Qualifications and Descriptions

Required minimum qualifications and brief position rationale, for descriptive purposes only, are outlined below. Each agency is responsible for submitting specific position descriptions and qualifications as part of their application.

For the following positions, **QUALIFYING EXPERIENCE** means: ***verifiable full or part-time case management or case work with the following populations: persons with or at high risk for HIV infection, and/or persons with a history of mental illness, homelessness, chemical dependence and/or other populations of persons in need. Experience with families preferred.***

Program Director:
Minimum Qualifications:

Master's degree in Health or Human Services, one year of supervisory experience and one year of qualifying experience;

OR

Bachelor's degree in Health or Human Services, two years of supervisory experience and three years of qualifying experience.

The multi-level team will be supervised on a regular basis by a program director. Once this person is chosen, the program director must be identified to the AIDS Institute. This person may not be a full time case manager. During start up of the CFP the program director can function as a supervisor/case manager for a portion of his/her time. It is required, however, that when 5-6 FTE staff are hired, the program director become a full time (100% FTE) position. Each agency should have a plan for the delegation of supervisory responsibilities, and must notify the AIDS Institute if there is a change or vacancy in the program director's position.

In conjunction with the agency's administration, the program director is responsible for the implementation of the work plan, oversees program development and evaluation, has knowledge of CFP fiscal status (revenues and expenses) and ensures quality client services. The program director supervises the case management staff, ensures timely billing and serves as the liaison with the AIDS Institute.

<u>Qualifications of Case Management Staff: (minimum qualifications)</u>

1. **Clinical Case Manager/Supervisor:**
   a. Masters degree in social work, human services or psychology.

   b. At least one year of supervisory experience and one year post-graduate experience working with families who have a history of substance use, mental illness, chronic homelessness, and/or HIV/AIDS.

The Clinical Case Manager/Supervisor works with case management teams to provide clinical supervision, and provides case management services to clients and their families who present with mental health and/or substance use issues. The CCM/S does not carry a case load, but is able to provide crisis intervention to help clients and/or family access ongoing mental health services, therapy, or rehabilitation services. Clinical case managers work directly with the case management team to guide and support their work. The position may be either full or part-time. (Please refer to Appendix A for more information and guidance regarding the Clinical Case Manager/Supervisor.)

2. **Treatment Adherence Case Manager:**
   a. Masters Degree in health education, public health, social work, or NYS licensed Registered Professional Nurse (BSN preferred). At least one year of supervisory experience and one year post-graduate experience working in medical case management or as a medical social worker. Experience working with HIV/AIDS and Antiretroviral treatments required.

   OR

   Bachelors Degree in health education, social sciences, or related field, or professional nurse(RN) degree or LPN. At least two years of experience in medical facility or community-based treatment adherence counseling, health and treatment education, or

medical case management. Experience working with HIV/AIDS and Antiretroviral treatments required.

Treatment Adherence Case Managers work with case management teams to provide clinical and case specific supervision and case management services to those clients and their families who present with treatment adherence issues and/or unstable status related to disease management. This position would not carry a case load, but would: serve as a liaison to the medical and case management treatment teams; provide individual, family, and group adherence support and education; coordinate and conference with the medical system; and, provide technical assistance to case management staff regarding disease and medication management. The Treatment Adherence Case Manager would work directly with the case management team, enhancing/supporting the work they are doing. This position could be either full or part-time. (Please refer to Appendix B for more information and guidance regarding the Treatment Adherence Case Manager).

3. **Case Manager:**

a. Bachelor's degree in health, education or human services (preferred) or RN *AND* one year of case management or case work with persons with HIV/AIDS, a history of mental illness, homelessness, chemical dependency, and/or other populations of persons in need.

OR

b. Associates degree in health, education or human services (preferred) or LPN or Certification as a CASAC *AND* two years of case management or case work with persons with HIV/AIDS, a history of mental illness, homelessness, chemical dependency, and/or other populations of persons in need.

OR

c. 60 credit hours of college study from a regionally accredited college or university or one recognized by the NYS Education Department as following acceptable educational practices *AND* two years of case management or case work with persons with HIV/AIDS, a history of mental illness, homelessness, chemical dependency, and/or other populations of persons in need.

The case manager is responsible for providing intensive case management for clients and their families/support system and advocates aggressively for clients to obtain the full range of needed services and ensures coordination of these services. The CM promotes linkage development and monitors the effectiveness of linkages with other service providers. The CM ensures community follow-up to engage the client in care, promotes compliance with medical appointments, and encourages client self-sufficiency and empowerment. The CM supervises the case management conducted by other members of the team (CMT and CFW) and is responsible for ensuring that all team member's documentation and billing records are complete and up to date.

4. Case Management Technician:

a. Associate's degree (or 60 credit hours of college study—see above) in health, education or human services (preferred), or LPN or Certification as a CASAC *AND* one year of case management or case work with persons with HIV/AIDS, a history of mental illness, homelessness, chemical dependency, and/or other populations of persons in need.

OR

b. High School diploma or GED AND two years of case management or case work with persons with HIV/AIDS, history of mental illness, homelessness, chemical dependency, and/or other populations of persons in need.

The CMT assists the case management team in the provision of intensive case management activities to support clients and their families in accessing needed services. The CMT makes phone calls to appropriate agencies to advocate for services, conducts home visits and community follow-up to monitor services and the client's status. The CMT maintains relationships with service providers and referral sources and participates in case conferences. The CMT maintains up-to-date case records and billing activity logs.

5. Community Follow-up Worker:

a. High School diploma or GED preferred,

OR

b. ability to read and write, understand and carry out directions, knowledge of community resources, sensitivity towards persons with HIV, and bi-lingual preferred.

The CFW assists the case management team by having frequent client contact in the home and in the community. When necessary, escorts clients to ensure that appointments are kept, and assist clients with ADLs and child care in crisis situations. The CFW helps family members provide support to the client to meet service plan goals. The CFW assists with scheduling of appointments, keeps simple records and participates in client case conferences, and engages in case finding activities such as targeted outreach to community organizations, churches, youth groups. The CFW reports to the CM (and/or the CMT).

C. Training:

Community Follow-up Program agencies are responsible for training case management staff. A schedule of training days, based on an individual's time within the agency's COBRA program, is applied to the number of required training days per year. The schedule is as follows:

- 11 days per year for first 2 years
- 6 days per year from 2 to 5 years
- 5 days per year after 5 years.

Providers must maintain a training log documenting the provision of training to all case management employees. Training logs must indicate by employee: the date of hire in the COBRA program, the type of training, who provided the training and length for each training session. Certificates of completion should be kept on file in the employee's personnel file. Training can occur in a variety of ways: in-service presentations, distance learning (online training), or through formalized training workshops. (If distance learning is accessed, retain the outline and/or objectives and curriculum in training log as well as certificate of completion. The supervisor must also verify that the online training was completed.)

Appropriate orientation to the HIV Confidentiality Law and the CFP should be provided for all CFP employees prior to contact with clients.

The following topics are required **program** orientation trainings for all new case management staff within three months of employment:

- HIV Confidentiality Law
- Child Abuse and Neglect-Mandated Reporter Training
- Billing training
- Basic Infection Control (universal precautions)
- Corporate Compliance Policy (which should include review of Whistleblower Policy).

Annual training must include the following:

- HIV epidemiology and health care
- HIV and TB
- HIV prevention/risk reduction education
- HIV/AIDS Confidentiality update
- Mandated Reporter refresher
- COBRA Billing update/refresher
- Corporate Compliance Policy review (which should include review of Whistleblower Policy)
- Infection Control refresher.

Other topics that should be addressed in orientation, agency in-service presentations and ongoing training include:

- Core case management training (offered by the AIDS Institute Regional Training Centers)
- Advanced case management trainings (offered by the AIDS Institute Centers for Expertise in Case Management)
- Documentation and billing
- Communication/interviewing skills
- HIV counseling and testing
- Hepatitis
- Interdisciplinary case conference
- HIV/AIDS treatment update
- Harm Reduction/Behavioral Counseling
- Treatment Adherence
- Domestic Violence
- Boundaries and Counter-transference
- HIV as a Long Term/Chronic Illness
- Personal Safety
- Aging
- Sexuality and HIV
- Transgender Issues
- Partner Notification

- Psychosocial aspects of HIV infection
- Substance use issues
- Maternal/child health issues
- Legal issues (e.g., permanency planning)
- Cultural sensitivity/attitudes/values
- Accessing entitlement systems
- Death, dying and bereavement
- Ongoing medical updates
- Identifying and accessing services
- Mental health/mentally ill chemical abusers
- Family centered case management
- Stress/burnout reduction
- Disclosure

*Training is not limited to those cited in this document. Training is available from a variety of sources and is appropriate as long as it is relevant to HIV/AIDS and case management work with this population. Participation in an HIV/AIDS conference would also be considered a training opportunity.

D. Contact Frequencies:

While many clients can benefit from case management services and may not require intensive, comprehensive case management, the majority of the CFP's clients are expected to require intensive personal contact by case management staff and have comprehensive service needs. The CFP agency should be prepared to provide this model of case management. For these clients, programs should comply with the following client contact frequencies:

- A minimum of 3 contacts per month, at least once face to face;
- At least four (4) should be face to face contacts with the case manager every 180 days, other contacts can be completed by other members of the case management team;
- Home visits should occur at assessment/reassessment, and as needed based on the individualized needs of the client/family.

Transitional Status

For those clients with whom a case management relationship has been established and who experience periods of stability, not requiring intensive case management, CFP participation may continue in a less intense manner. Conversely, clients who are noncompliant in service acquisition or who are lost to follow-up may also receive less intensive case management, while attempts to engage or locate them are continuing. The recommendation to transfer a client to "stable or transitional status" should be approved by the CFP Program Director.

Criteria for Transitional Status

1. Service Plan reflects maintenance or life enhancing goals; client and family stability for at least 180 days.
2. Basic needs are met, including: medical health and stable housing
3. Client demonstrates ability to function independently
4. Non-adherent or lost to follow-up client for 3- 6 months (consistent and aggressive attempts must be undertaken to try and re-engage client back into services)

Note: prior to placing a client into transitional status the following must first take place: a reassessment including a home visit and case conference(s) with other providers. CFP must also develop a transitional service plan with mutually agreed upon goals to be worked on. Evidence of CFP compliance will be requested at monitoring visits.

Clients with transitional status classification can return to "Intensive Status" if they experience a crisis period or require more intensive services. It is important to note that transitional status may ONLY be used for clients who have been on intensive status (i.e. clients should not be directly enrolled into this status)

PROGRAM CRITERIA

The ratio cannot exceed 75% intensive needs/25% transitional status. (i.e. for a CFP total case load of 200, it would be 150 intensive clients and 50 transitional status clients). Transitional status clients should be identified as such.

Duration of Status:

Transitional status should be limited to one reassessment cycle. Extensions may be granted in very limited cases with written justification. The Program Director will monitor all transitional status as well as sign-off on all extension requests.

Transitional Status Contact Frequency:

A minimum of one client contact per month must be maintained as required under Comprehensive Medicaid Case Management regulations. Additionally, there must be a minimum of three (3) face to face contacts every 180 days and a minimum of one (1) home visit at reassessment. Reassessments must be conducted every 180 days and service plans developed in conjunction with the reassessment. Open case records on clients who are not located or do not become involved in service planning must be closed after six months.

Contact frequencies should be specified in the application, with an identified percentage of those clients who will require less intense contact frequencies.

E. Client Caseloads:

Client caseloads will vary based on team composition. To facilitate the intensive case management required by this program, the recommended caseload for a team of two billable FTEs and one community follow-up worker is thirty-five to forty clients. A case manager may provide services to a maximum of twenty clients. Caseloads may be increased by ten clients for each case management technician and/or community follow-up worker under the supervision of the case manager.

However, as indicated in the contact frequencies section, over time it is expected that some cases will require less intensive case management. A few may only require monthly follow-up contacts. As this occurs, the case manager's caseload may increase to twenty-five clients. The maximum caseload for a team of three (CM, CMT, CFW) with a caseload mix would be forty-five clients.

While there is no mandated caseload minimum, it is necessary to have an adequate number of clients, in order to generate a sufficient number of billable hours and have fiscally viable programs. (This issue is discussed in more depth in the CFP Billing Information section).

V. Service Delivery – Requirements

A. Comprehensive Medicaid Case Management (CMCM) Regulations

Case management is included as a discrete and reimbursable item of service under the New York State Department of Health Medical Assistance Program and is governed by a set of regulations (Section 505.16). These regulations set forth the scope of case management services and requirements relating to program activity, record keeping and reporting. The CMCM regulations are found in Appendix C.

B. AIDS Institute Program Standards

Through case management, clients receive assistance in the coordination and expedient access to a range of appropriate medical and psychosocial services for the client and family. The goal is to promote and support the independent functioning of the individual and his or her family unit.

Under the Community Follow-up Program, case management is viewed as a multi-step process comprised of the following activities.

- Case Finding
- Intake
- Assessment
- Service Plan Development
- Service Plan Implementation
- Advocacy
- Interagency Coordination

- Monitoring
- Reassessment
- Service Plan Update
- Crisis Intervention
- Case Closure/Exit Planning

CFP provider agencies will be expected to conduct all of these activities, in compliance with the case management standards issued by the AIDS Institute. The case management definition and program standards can be found in Appendix B & C.

The AIDS Institute program standards and CMCM regulations describe the service components which programs must provide and quality standards which must be adhered to. They will be used to monitor client service delivery and program performance.

C. Documentation

Each CFP provider is responsible to:

Maintain a separate case record for each client which includes:

- case identifying information
- eligibility for target population
- initial referral information including the source and date of referral
- client's voluntary consent for CFP case management, noting that program information was provided to client at intake
- local social service department registration notice
- intake
- assessment/reassessments
- comprehensive service plans which include goals, objectives, time frames and outcomes
- monitoring/progress notes of client and collateral contacts
- written referrals, case correspondence
- client consents to release information
- crisis intervention services
- exit/case closure summary

Per federal regulations, to secure payment for case management services rendered, the progress notes must document:

- the date of service
- the place/type of service (e.g., phone call, home visit)
- who was contact between (e.g., partner of client contacted case manager); case management staff should sign/initial each progress note the nature and extent of the service (e.g., what happened); ***the case management service should support the goals and objectives as described in the service plan***
- outcomes such as referrals (e.g., name of provider agency and person providing service)
- amount of actual time spent on the case management activity

The AIDS Institute has developed specific case management documentation. These include the consent, intake, assessment, reassessment, service plan and exit summary forms. These will be provided to agencies during the application approval process.

Providers may propose the use of their own forms for use in this program. This documentation must be submitted to the AIDS Institute for approval prior to program implementation.

Other records

Each CFP provider must maintain other records to support the basis for payment for the case management program, including referral agreements, provider agreements, memorandums of understanding, approved work plans, training/meeting logs, records of costs incurred and revenues received in providing services, employment and personnel records which show staff qualifications and time worked, records of all services provided and any other records required as a result of any agreements with the New York State Department of Health or the AIDS Institute.

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

D. Crisis Intervention

Each CFP provider is responsible for the development and implementation of crisis intervention procedures for clients. The CFP crisis intervention requirement is two-fold.

1. Twenty-four hour crisis intervention services must be made available to CFP clients for emergencies during non-working hours. These services can be provided by CFP staff or through formal agreements with other programs or service providers (internal or external). Other types of crisis intervention services include contractors/subcontractors such as:

    - agency-wide crisis intervention/hotline programs,
    - county, regional hotline services, and
    - mobile crisis teams.

    If CFP staff provide crisis intervention services after work hours each staff person must be trained in crisis intervention, with documentation of such included in the training log.

    If CFP staff do not provide the crisis intervention services, there must be formal written service agreements and protocols in place and on file. The protocols must include a description of a mechanism to relay information to CFP staff, within the confines of confidentiality and within 24 hours or the first business day after the crisis occurs.

2. A crisis intervention plan must be developed with each client. This plan becomes part of the service plan and must be reviewed with each client as part of their reassessment. The

plan should include a discussion on what constitutes an "emergency call" and the identification of who to call in each type of emergency.

A formalized crisis intervention system must be in place within six months of the program's operational start date.

E. Freedom of Choice and Client Consent

Clients participation in the CFP is entirely voluntary and they must be assured that their choice to accept or reject CMCM services will not affect their Medicaid eligibility or access to other services the agency provides.

Clients must be assured that no restrictions will be imposed on their choice of provider of case management or any other service provided under Medicaid. However, clients may only enroll in one CMCM program. Additionally, case management under the CFP must not duplicate case management services currently provided under other AIDS Institute or other Medical Assistance Programs.

If a client agrees to CMCM under the CFP, the agency must obtain written client consent at the time of Intake. The client is asked to consent to the following:

- received information regarding the CFP,
- understands their freedom of choice of provider, and
- registration with the local department of social services.

Once a client consents to CMCM under the CFP, they may decline services or other elements of the service plan.

F. Client Confidentiality

Case management agencies are required to comply with the New York State HIV Confidentiality Law, and are responsible for protecting the confidentiality of all HIV related information they receive in the course of providing client services. Additionally, clients have the right to confidentiality with regard to all information shared with the provider. They must ensure that written client consent to release information is obtained, and that persons who receive HIV related information are aware that they are prohibited from further disclosure without the specific written consent of the client.

G. Social Services Department Registration

CFP providers must submit a request to register the Medicaid client to the designated local department of social services unit, prior to billing for CMCM services. The request must contain the provider agency's name and MMIS provider ID number. The request must also list each client by name, Medicaid ID number and the date on which the CMCM intake service took

place. It must be accompanied by a signed agency statement attesting that:

- each client is a member of the target CMCM population and documentation for eligibility is in the case record, and
- each client freely accepts service and that the client's signed statement to that effect is in the case record.

Upon registration, the local department of social services will assign Welfare Management System (WMS) Code 35, which is a specific code for CMCM. It should be noted that clients enrolled in CMCM with Code 35 are exempt from co-pays and utilization thresholds. Also, persons enrolled in Managed Care Programs are eligible to participate in CMCM. Providers are required to promptly notify the designated local department of social services unit of changes in a client’s status which affect continued program eligibility.

A process for registering clients in the counties the provider will be offering services must be in place prior to implementing the CFP. It is required that you inform the local department of social services of your intent to apply for the CFP and that open discussions regarding registration of clients and coordination of services continue throughout the application process and program's operation.

H. Agency Location:

Ideally, CFP providers will have sites that are within one mile of public transportation, and have offices that are accessible to clients with disabilities and those with infants and toddlers. Agencies whose sites do not meet these criteria must give consideration to how they will accommodate all CFP clients.

I. Insurance:

All CFP agencies must maintain insurance to protect both the agency and the State from any sanctions brought as a result of participation in this program.

VI. Quality Assurance – Requirements

A. Agency Quality Assurance

Each CFP provider is responsible for the development and implementation of a quality assurance plan. It should minimally include the following elements.

1. Ongoing staff supervision with annual staff evaluations.
2. Case reviews. At a minimum, case supervision occurs for:
    - all new intakes to determine appropriateness for the program,
    - the initial client assessment and service plan to ensure the comprehensiveness of the assessment and that the service plan addresses immediate and long term needs,
    - all reassessments and revised service plans,

- cases requiring repeated crisis intervention, and
- cases being closed.

These reviews ensure that documentation is in compliance with AIDS Institute standards and CMCM regulations and that case management services are relevant to the identified and emergent needs of the client. These reviews also evaluate the effectiveness of case management interventions and identify barriers case managers face in meeting client goals. Procedures should be implemented to ensure that corrective actions take place in a timely fashion.

3. Peer review at which case management staff present and discuss specific client cases.
4. Quarterly random review of active and closed cases by other objective reviewers (e.g., QA consultant, agency quality assurance/utilization review department, clinical supervisor).
5. Client participation which includes the dissemination of a client satisfaction survey to provide consumer-based feedback on CFP services. We encourage programs to also involve HIV infected individuals in program planning, development and evaluation.
6. In addition to client care QA, the quality assurance program includes an ongoing administrative review of the CFP's function within the organization and implementation of the work plan for program planning and evaluation purposes.
7. Development of a CFP Policy and Procedure Manual.
8. Development of an agency Compliance Policy and appointment of a Compliance Officer.

This comprehensive quality assurance program should be fully implemented within one year of a program's start date.

B. Agency Reporting

All CFP agencies are required to submit the following to the AIDS Institute:

- quarterly client data reports;
- quarterly revenue and expense reports;
- detailed annual program and cost reports (corresponding to the calendar year); and
- work plan and budget summary for each prospective year.

C. NYS Department of Health AIDS Institute Monitoring

CMCM regulations require that the AIDS Institute is responsible for on-site monitoring visits every six months. Site visits will be conducted by AIDS Institute and/or contractor staff. The purpose of monitoring is two-fold:

- to determine whether program implementation, administrative operations and service provision follow the work plan and proposed goals; and

- to review client case records to confirm that cases are maintained in a manner consistent with AIDS Institute guidelines and CMCM regulations, as well as to ensure that clients are receiving quality case management to meet needs as identified in the assessment and service planning process.

A monitoring report will be provided to the CFP agency. Corrective action plans may be required and will be discussed in the monitoring report. Subsequent site visits will verify the implementation of the corrective action plan and judge progress made in connection with other program and/or case management issues which were identified in the report.

VII. Community Follow-Up Program – Billing

During the application approval process, a Medicaid program enrollment package is sent to pending applicants. Following approval by the AIDS Institute and the State Division of Budget, providers are given a Medicaid Provider ID number, issued a MMIS provider manual, and billing instructions. Case manager and case management technician time spent in the completion of the required case management activities, listed under Program Standards and CMCM Regulations, client/case-specific supervision and case conferences are directly billable at the approved quarter hour reimbursement rate. Program administrative costs, including Community Follow-up Worker and other CFP personnel costs, are not directly billable; however, these salaries are supported by the reimbursement rate. A more detailed list of specific billable activities, as well as non-billable and non-fundable activities follows.

A. Comprehensive Medicaid Case Management Activities

B I L L A B L E

Billable Comprehensive Medicaid Case Management (CMCM) activities are those CMCM activities provided by case managers and case management technicians directly to, or on behalf of, Medicaid eligible members of the CFP target population who have freely accepted services and have been authorized for CMCM services from a specific CFP provider. These activities include:

1. INTAKE AND SCREENING

- initial contact, provision of information on the CFP and screening of eligible clients who accept CMCM services
- interview and collect intake data
- providers may bill for intake/screening activities in an acute care hospital when discharge is imminent; intake, screening, and other discharge planning activities may not be billed for other institutionalized individuals (i.e., prison, residential drug treatment, etc.)

2. ASSESSMENT AND REASSESSMENT

Assessment includes:

- identification of clients strengths, resources, problems and needs
- review of clinical care, substance use, TB history, etc. to determine utilization and adequacy of medical care
- identification of barriers to care and existing gaps
- a comprehensive evaluation of service needs and problems
- obtaining information about the client's support system
- input of relevant professionals/other agencies serving client (with the client's permission)
- home visitation
- documentation of assessment information (completion of form)

Reassessment includes:

- updating, revising the above information with the client/support system (every 180 days, or earlier if circumstances warrant)
- case conference with all agencies involved in the service plan
- verifying the client's current functioning and continuing need for services
- making necessary revisions/additions to the client's service plan
- home visitation

3. CASE MANAGEMENT PLANNING AND COORDINATION

- the case manager, in conjunction with the client/support system, identifies long and short term goals
- specification of activities to reach the goals and anticipated time frames
- identification of the array of services, and interventions and activities needed
- with participation of the client and support system, selection of services to meet identified goals, and case manager/client activities
- identification of informal support network and service providers
- collaboration; including case conferencing
- written documentation of the plan in client case record

4. IMPLEMENTATION OF CASE MANAGEMENT PLAN

- learning about community services to meet a specific clients needs
- negotiating services delivery and responsibilities
- securing service delivery
- assisting with referrals, and/or completing application forms.

- education to help clients understand the reason for a particular service and to help clients seek services on their own
- counseling/education directed at ensuring a client's cooperation with, and which facilitates their understanding of service acquisition
- advocacy
- establishing alternate plans to avoid disruption of services
- interagency coordination and negotiation to ensure continuity of care

5. MONITORING AND FOLLOW-UP OF CASE MANAGEMENT SERVICES

- telephone, agency, office, and community follow-up contacts to:
    - verify client participation
    - verify quality of services
    - ascertain client satisfaction
    - document client progress
- ongoing updating and revision of case management plan
- developing alternative arrangements if services are denied or unavailable
- assisting in resolution of disagreements
- ensuring ongoing services
- anticipating barriers/difficulties and mediating on behalf of the client
- facilitating access to other appropriate care

6. CRISIS INTERVENTION

- assessment of emergency situation
- determination of service needs
- securing emergency services
- revision of case management plan

7. CASE CLOSURE

- exit planning related to a client's impending death, such as linkage and referral to support and concrete services for case collaterals
- in cases, other than client death, linking the client with appropriate ongoing case management or other needed services
- preparing a case summary, stating reasons case is being closed and services rendered to the client/support system
- with client permission, forwarding case summary to new provider(s)

8. OTHER

- case management activities for clients who are expected to be hospitalized for less than 180 days.
- case specific supervision
- travel to client's home, or other site and return

- accompanying clients to providers to the extent that it is necessary to help them negotiate the service delivery system and ensure acquisition of services.

F U N D A B L E

Non-billable, but fundable CMCM activities are those activities essential to the provision of CMCM services that are not client-specific. These activities may **not** be billed for directly, but they are funded indirectly through the reimbursement rate. Such activities include:

1. case recording of progress notes
2. training and conferences
3. supervisory conferences and meetings (not related to specific clients)
4. administrative inter-agency networking and community resource development
5. intake and screening clients who do not accept services
6. client engagement while in institutional settings, other than acute care hospitals
7. case management activities for enrolled clients who, at the time of admission, are expected to be hospitalized or institutionalized over 180 days
8. completion of billing forms

N O N - F U N D A B L E

Non-billable, non-fundable activities are those activities that are not a proper function of CMCM and the cost of such activities may be neither billed for directly, nor included in determining the reimbursement rate. These activities include:

1. counseling, such as:
    - drug and alcohol counseling
    - group counseling
    - social work therapy or therapeutic counseling
    - employment counseling
2. medical assistance eligibility determinations
3. discharge planning responsibilities of hospital staff
4. fiduciary activities
5. any other services which are covered by Medicaid or third party funding sources (i.e., medical care, HIV testing)

6. other direct services (i.e., shopping, delivering food baskets)
7. outreach to non-eligible populations
8. child care expenses
9. client travel expenses
10. volunteer recognition costs

B. <u>Billing for CMCM Services:</u>

Time spent on billable CMCM activity must be converted to units of service, which are required on the MMIS Claim Form. Therefore, providers must maintain a record of the amount of case management service time rendered to each individual for billing purposes. All the cases a particular billable staff serviced during the month should be entered on a form. For example, a Case Manager Daily Time Sheet lists the number of minutes of service provided to an individual on a particular day. A billing clerk may then convert the number of service minutes listed on the Case Manager Daily Time Sheet to billing units on the MMIS claim form.

Billing is as follows:
1 Unit = 5 minutes - 15 minutes
2 Units = 16 minutes - 30 minutes
3 Units = 31 minutes - 45 minutes
4 Units = 46 minutes - 60 minutes

<u>Example:</u> 20 minutes spent with a client in relation to their service plan + 10 minutes spent making a referral for the individual + 5 minutes spent in verifying service arrangements = 35 minutes of billable activity. This converts to 3 units of service.

* Once you become an authorized CFP provider, you will receive the Comprehensive Medicaid Case Management Program Manual, for assistance in billing New York State Medicaid Management Information System (MMIS). It explains all information necessary to submit claims to Computer Sciences Corporation for services rendered to CFP clients (MMIS has a contractual agreement with this agency to handle payment for Medicaid claims). Training from Computer Sciences Corporation can also be arranged.

C. <u>Billing/Revenues/Expenses</u>:

Each CFP provider is responsible for tracking CMCM billing, revenue received and program expenses. Records of expenses and revenues must be kept by calendar month. This information must be accessible to the Program Director.

VIII. Budget

A new reimbursement structure for the Medicaid community follow-up program has been approved by the Division of Budget effective April 1, 2010. The new rate structure replaces the prior regional three-tiered rate structure with a single rate for each of three regions:

- New York City,
- Metro (Long Island and Westchester), and
- the rest of the state region.

The basis on which claims are submitted - a quarter-hour unit of service – is maintained with the new rate methodology. Rates are pre-determined by region and are not provider specific, offering a price that the State is willing to pay for a billable service. The new rates are presented in the table below:

Region	Approved rate Effective 4/1/10
New York City	$99.51 per hour or $24.88 per quarter-hour
Metro (LI / Westchester)	$105.61 per hour or $26.40 per quarter-hour
Rest of the State	$86.06 per hour or $21.51 per quarter-hour

Pricing was established based upon a hypothetical caseload deemed appropriate for each region of 200 clients in New York City and Metro regions and 100 clients in the rest of the state. This caseload mix is utilized to assure providers will meet AIDS Institute standards for service delivery and for staff qualifications. The resulting staffing models, salaries and non personal service costs were prepared with the combined analysis of provider cost reports and regional agency information.

Models used for rate derivation are not meant to be prescriptive. The rates provide agencies with the flexibility to employ alternative configurations of direct service staff (e.g., a New York City or Metro region provider may employ a different mix of case managers, case management technicians, and community follow-up workers than presented or an agency serving an area in the rest of the state may employ a community follow-up worker) as long as the agency meets the Institute's program standards for case management service provision.

Direct Services

a. Direct Services – Staff

New York City and Metro (Long Island, and Westchester) Regions

Position	Salary	FTE	Total Cost
Program director/supervisor	$ 65,000	0.75	$48,750
Case manager	$ 42,000	6.00	$252,000
Case manager technician	$ 35,000	6.00	$210,000
Community follow-up worker	$ 27,000	3.00	$81,000
Treatment adherence case manager/ Supervisor	$ 49,000	0.50	$24,500
Clinical case manager/supervisor	$ 53,000	0.50	$26,500
Total FTEs and Salaries		16.75	$642,750

Rest of State

Position	Salary	FTE	Total Cost
Program director/supervisor	$ 50,000	0.75	$37,500
Case manager	$ 36,000	6.00	$216,000
Clinical case manager or treatment adherence case manager/supervisor	$40,000	0.50	$20,000
Total FTEs and Salaries		7.25	$273,500

In this example, 75 percent of the Program Supervisor/Director costs are included under direct costs, this may vary by organization. The responsibility of program director/supervisory staff includes quality assurance activities directly related to case management service provision and is thus a direct cost component. The remainder of the effort of these positions is devoted to activities unrelated to direct service provision and is accommodated in the indirect cost component of the rate.

b. Direct Services – Fringe Benefits

Fringe benefit costs were calculated as a percentage of salaries, based on an analysis of provider cost reports. The percentages used for rate development are:

- 30 percent for the New York City and Metro regions
- 26 percent for the rest of state.

c. Direct Services – Non-Personal Services:

Non-personal direct services costs include the cost of space, travel, quality assurance, supplies, training, conferences, telecommunications, utilities, relevant subcontractor/ consultants and other items necessary to direct service provision. Travel costs were determined using the cost of twelve monthly MetroCards for each team member in New York City and $5,000 per case manager in rest of state regions.

Indirect Costs

The indirect cost component of each region's rate is limited to 10 percent of the direct service costs, consistent with guidelines provided by the federal Centers for Medicare and Medicaid Services. Indirect costs include a portion of Supervisory /Program Directors salary as well as non-direct personal service costs which are not directly related to case management service delivery such as secretary, billing clerk and administrative positions.

Total Costs and Billable Hours:

Total allowable costs are the sum of the direct services costs (personal, fringe benefits, and other non-personal services costs) and indirect costs. The approved hourly rate was calculated by dividing these total allowable costs by the number of billable hours of service provided by case management staff. The number of billable hours per staff person is calculated as follows and is consistent with the billable hours calculation in the prior rate methodology:

Total hours: 35 hours x 52 weeks = 1,820 hours per year

Total hours unavailable for service: 30 days x 7 hours per day = 210 hours per year.

This 30 day deduction from time available for providing direct services allows for non billable time for skills development training, staff development network activities and personal time. These activities are critical to the delivery of quality HIV case management service and allow for improved services to clients.

Total hours available for service: 1,820 hours – 210 hours = 1,610 hours per year

Total billable hours: 1,610 x .55 = 888.5 hours per year

As with the prior rate methodology, 55 percent of staff time is available for direct service provision with the remaining time used for chart documentation, internal staff meetings, and other administrative activities.

Note: Costs associated with direct client services continue to be non-fundable and may not be included in your budget. (counseling, support groups etc.)

IX. Required Submissions to the AIDS Institute:

- Annual work plan submission is due in January each year. Detailed line item budgets and justifications are not required. A summary budget worksheet and brief line item description will be required as part of the annual work plan package. This will assist your agency with fiscal and program planning. The summary budget worksheet is also used by the AIDS Institute in reviewing your budget to determine if your expenditures are likely to be fully reimbursed under the rate structure.

- Annual Cost report is required five months after the close of a calendar year.

- Quarterly fiscal reports are required 30 days after the end of each quarter.

- Written notification is also required for any staffing changes during the year.