

**HIV CASE MANAGEMENT
AND SUPPORT SERVICES:**

**STATE MANAGED SERVICES
POLICIES & PROCEDURES**



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State Managed Services (SMS) – Policies and Procedures

Policies and Procedures described in this document should be used as an addendum to the HIV Case Management and Support Services, Program Policies, Services Definitions & Guidance document.

Name of Policy and/or Procedure: **Eligibility**
Purpose: Defines who is eligible and who determines eligibility.

Policy

HIV case management providers are responsible for determining client eligibility. Clients receiving SMS are determined to be eligible by the case manager in accordance with the requirements outlined in the *HIV Case Management and Support Services, Program Policies, Services Definitions and Guidance*. Submission of a SMS request form verifies HIV status and income eligibility for services.

Name of Policy and/or Procedure: **Request Form Process**
Purpose: Defines what is needed to process the request

Policy

SMS requests must be made by an HIV Case Manager (CM), Care Coordinator (CC) or HIV Medical Case Manager (MCM) and must be submitted on the standard "State Managed Services Program Request Form" (Request Form). If multiple services are requested for one client, a separate form must be submitted for each service.

Mental Health, Substance Abuse, Home Health and Medical Nutritional Therapy require separate approval for both the initial assessment and the service (it is not necessary to request payment for the initial assessment if this will be paid by another funding source- i.e. by the client). The initial assessment must be approved separately from the approval for the actual service. The SMS program will pay for one initial assessment per service category per client per fiscal year up to \$300 (does not apply to Dental Services).

Dental Services are authorized in two phases. Phase 1 services require submission of a Request Form and may be authorized without attaching a dental treatment plan. Phase 1 services are intended to cover the first dental appointment up to \$500 and must result in the development of a dental treatment plan if Phase 2 services will be

requested. Phase 2 services require submission of a separate Request Form, as well as a dental treatment plan completed by the dental clinic/dentist that will be performing the services. It is not required that Phase 1 services occur before Phase 2. In some situations it may be appropriate to only request Phase 2 services; however, a treatment plan must always be submitted to obtain a Phase 2 authorization.

Important: Clock Tower Dental Clinic is an HIV specific comprehensive dental clinic which receives reimbursement through Health Resources and Services Administration for some of the dental care they provide. Dental care provided by Clock Tower Dental Clinic is very cost effective. Clients should be referred to Clock Tower Dental Clinic unless extenuating circumstances apply. Extenuating circumstances may include, but are not limited to, illness, pain, disability, family/work responsibilities, travel distance/weather and must be documented in CAREWare Case Notes.

Clients residing in the HIV Alliance service area do not qualify for SMS dental services through this process and must use the locally managed process for service authorization.

Procedure

The completed Request Form must be submitted via confidential fax to the SMS Program at 971-673-0177. If more than one service is being requested for the same client, a separate request must be submitted for each service and a separate authorization will be sent for each service requested. If the request is for the initial assessment for Mental Health, Substance Abuse, Home Health or Medical Nutritional Therapy, the request form is faxed for authorization of the initial assessment only. The service will not be authorized until the program receives the service plan. It is not necessary to submit a second request form along with the service plan.

All providers must be pre-authorized by the SMS Program, including additional providers or referral to another provider by the originally authorized provider. The CM/CC/MCM must send the SMS Program the additional provider's contact information. In this case, a revised Request Form must be submitted. In the case of a revision to a previously authorized service, the requesting case manager will receive an email verification of receipt.

The services cap is applied to the client and is not based on the number of authorized providers for each client. The CM/CC/MCM is responsible for making sure that the client and providers understand that they are sharing the maximum amount for the service. The program will only pay up to the maximum service capped amount on a "first-billed first-paid" basis.

Name of Policy and/or Procedure: **Service Plans**

Purpose: Describes the service plan requirement for dental, mental health, substance abuse treatment and home health care services.

Policy:

The SMS program requires a service plan/treatment plan to be submitted with the Funding Request Form for the following services:

1. Dental Services (Phase 2 Only)
2. Mental Health Treatment
3. Substance Abuse Treatment
4. Home Health Services
5. Medical Nutritional Therapy

The Service Plan form cannot be used for Dental Services. Only a treatment plan provided by the dentist will be accepted for Phase 2 services.

Name of Policy and/or Procedure: **Authorization/Denial Process**

Purpose: Describes authorization and denial of a request.

Policy:

Within two business days of receiving a complete application, the Program will issue, via secure email, a "Service Authorization" form indicating whether the requested service was accepted or denied. All requests will be accepted unless the following occurs:

- Client has used maximum funds allowable within the service year.
- If the CM requests more than the capped dollar amount (with the exception of Dental Services).
- Funding is not available (this is determined by the HIV Care and Treatment Program).
- The client is eligible to receive the service requested through another program (i.e. Federally Qualified Health Center, Federally Funded Dental Clinic, insurance provider). **SMS funds are the payer of last resort.**
- There appears to be a conflict of interest.

Procedure:

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1. The Grants Assistant will date stamp the Request Form upon receipt (fax machine will automatically stamp the time/date on the Request Form).

2. The application will be reviewed for completeness and eligibility. Incomplete Request Forms will be sent back to the CM/CC/MCM or the additional information will be obtained by the Grants Assistant.
3. Grants Assistant will review individual client's services history to assure that the client has not reached the dollar cap in the services category.
4. Within two business days from receipt, the Grants Assistant will issue, via secure email, a Service Authorization form to the CM/CC/MCM (either denying or approving).

Name of Policy and/or Procedure: **Authorization Expiration**
Purpose: Defines expiration of authorizations.

Policy:

Authorizations will expire on June 30th of each year. CM/CC/MCMs will receive a 30-day notice from the SMS Program that all active client files will expire on June 30th. The CM/CC/MCM must submit a new Request Form to continue services into the next service year (beginning on July 1st of each year). Funding carry-over from one year to the next is not allowed.

Procedure:

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1. In May of each program year the Grants Assistant will send service expiration information to all CM/CC with an active client in the SMS program showing the amount of funds encumbered but not yet expended.
 2. By July 1st, all previous authorizations will be inactivated. To continue activation, the CM/CC/MCM must submit a new Request Form.

Name of Policy and/or Procedure: **Service Utilization**
Purpose: Defines requirement for service utilization.

Policy:

The first invoice must be received by the SMS program within 90 days of authorization. If after 90 days no invoices have been received, the SMS Program reserves the right to cancel the service authorization and a notice will be sent to the CM/CC/MCM.

Name of Policy and/or Procedure: **Data Entry**
Purpose: Defines data entry requirements.

Policy:

SMS data will be collected in the CAREAssist database.

Procedure:

The Grants Assistant will enter the following information into the CAREAssist database:

- Client demographics (name, address, gender, race, ethnicity, date of birth) – if the client is already a CAREAssist client then this information will need to be checked for accuracy.
- County of Residence– if the client is already a CAREAssist client then this information will need to be checked for accuracy.
- HIV/AIDS Status
- Housing/Living Arrangement
- Name of Case Manager– if the client is already a CAREAssist client then this information will need to be checked for accuracy.
- Client Unique Record Number (this number is auto generated)
- Client Encrypted Unique Record Number (this number is auto-generated)
- Service Authorized
- Encumbered Amount Authorized
- Authorization Start Date
- Authorization End Date (this will always be June 30th, or when authorized funds have been spent)

Name of Policy and/or Procedure: **Billing**
Purpose: Defines billing requirements.

Policy:

- Invoices must be submitted to the SMS Program by the authorized provider.
- Invoices must be received within 90 days of the date of the authorization.
- Invoices must include a Federal Tax Identification Number, unless provider accepts payment by VISA.
- All services must be completed by June 30th of the program year.

SMS will only pay bills submitted by the authorized vendor(s).

SMS will not pay for provider administrative charges, such as appointment charges when the client does not show up to the appointment.

Procedure:

If invoices are received past the 90 day billing requirement the program reserves the right to deny payment.

Name of Policy and/or Procedure: Insurance Policy

Purpose: Describes required processes for clients covered in part or in full by an insurance policy.

Policy:

If the client has an insurance policy the CM/CC/MCM must indicate this on the request form. **Additionally, the provider must submit the Explanation of Benefits (EOB)/Summary of Benefits (SOB)/Medicare Summary with the invoice(s) at the time of billing.** The program will reimburse at "usual and customary" rates as defined by the primary payer reimbursement schedule. The SMS program will not pay insurance contractual adjustment to the fees charged by the provider. The SMS program will only pay that portion owed by the client as determined through the standard billing process used for ALL clients of the service provider.

Name of Policy and/or Procedure: Service Funding Limits

Purpose: Defines service funding caps.

Policy:

Services funding is capped at the following amounts. Service definitions can be found in the Program Policies, Services Definitions and Guidance Document.

- Dental Services (Maximum benefit based on local assessment of need)
- Home Health Care- Paraprofessional, Professional/Specialized (Maximum benefit is \$2000 per client per year)
- Mental Health Services (Total Maximum Benefit is \$6500 per client per year)
- Substance Abuse Services (Total Maximum Benefit is \$5000 per client per year for all Substance Abuse Treatment services)
- Medical Nutritional Services (Total Maximum Benefit is \$2500 per client per year for all Medical Nutritional Services)

Name of Policy and/or Procedure: **Program Exceptions**
Purpose: Defines program exceptions.

Policy:

The program will not authorize requests over the capped amount described in the "Service Funding Limits" policy.

Name of Policy and/or Procedure: **Authorization Completion**
Purpose: Describes the process that occurs when a client completes the authorized service.

Policy:

CM/CC/MCMs are expected to contact the SMS program when a client is no longer using the approved SMS service (i.e. client moves, client does not want to continue services, client is not in case management). The program will close out the authorized client service file when permission is given by the case manager and the program will then reallocate those encumbered funds back into the SMS program with the exception of Dental Services (remaining funds will be placed back into the agency's dental funding allocation for the year).

A client may only be approved for an SMS service once per year. However, previously closed Phase 1 or Phase 2 authorizations may be re-opened within the same program year.

Changes in client income eligibility will not affect an authorized service period (unless the client is no longer engaged in case management services). If clients were eligible at the time the authorization was approved the SMS Authorization will be in effect until the end of the authorized service date.

Procedure:

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1. The CM/CC/MCM will inform the SMS program when a client's treatment plan has ended.
 2. The SMS Program will revise the previously encumbered amount within the database. For dental services, funds will be replenished to the agency's SMS dental fund.
 3. The Grants Assistant will complete the "Services Completed" form.

4. The Grants Assistant will attach the completed form to an email to the case manager and Clock Tower Dental if applicable, including a "cc" to the Financial Operations Analyst.

Name of Policy and/or Procedure: **Conflict of Interest**
Purpose: Defines the "conflict of interest" policy.

Policy:

The SMS program acknowledges the following as a "Conflict of Interest" and will deny/terminate services when knowledge of these situations occurs:

1. CM/CC/MCMs may not submit a Request Form for a member of their family (i.e. son, daughter, husband, wife, domestic partner). Requests may come from another case manager at the agency and must be reviewed and approved by case management supervisor.
2. CM/CC/MCMs may not sell, buy, trade, negotiate, or accept any services or items from a client or patient that would result in a benefit from the SMS program.
3. CM/CC/MCMs may not use information about a client or patient that was gained during employment funded by the local case management provider to further the employee's personal gain.

Name of Policy and/or Procedure: **Allocation of Funds**
Purpose: Describes amount of service available to each county.

Policy:

Annually, the program will determine the dollar amount for each SMS service in June of each year based on dollars available. The Financial Operations Analyst will assure that dollar amounts are appropriately distributed and correctly incorporated into the CAREAssist data management system by July 1st of the service year.

For Dental Services only:

In order to guarantee equitable access to a highly utilized service, each county/agency will receive a Dental Services funding allocation on July 1st of the service year.

Allocations are determined using the following formula:

- \$1500 base funding per case management contract agency
- 25% based on people with HIV/AIDS living in the service area (2 year average), as reported by HIV Surveillance.
- 75% based on the number of unduplicated clients served in the previous calendar year.

CM/CC/MCMs will be responsible for assessing client needs and prioritizing services based on the needs of the agency caseload. All funding requests will be drawn from the agency's Dental Services Funding Allocation; approving extensive services for one client will reduce the number of available funds for all clients served by the agency.

Name of Policy and/or Procedure: Reallocation of Funds Purpose: Defines reallocation of service funds.
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Policy:

The Program may re-allocate funds depending on services utilization.

Procedure:

Reallocation Process to Other SMS services:

The program will review the utilization of each service under the SMS program and may move funds from under-utilized services to higher-utilized services. This process may differ depending on current data and information provided by all agencies.