New York State Department of Health
AIDS Institute

COBRA Community Follow-up Program (CFP)

Request for Qualifications
Program Guidance

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. Proposals will be accepted from eligible applicants in all counties of New York State.

II. Need and Intent

As of December 2001, there have been nearly 149,000 AIDS cases reported in New York State, representing nearly 19 percent of the nation's total. Compared to total adult/adolescent AIDS cases in the United States, a greater proportion of New York's cases are among people of color (72.2 percent vs. 57.9 percent), injection drug users (41.7 percent vs. 24.7 percent), and women (23.6 percent vs. 17.3 percent). Through December 2001, over 2,268 AIDS cases in children under the age of 13 have been reported in New York State, representing 26.2 percent of all pediatric cases reported in the United States. In 2000, AIDS was the leading cause of death in New York City for females ages 30 to 34 years and males ages 30 to 49 years.

The HIV epidemic has had a disproportionate impact on New York's communities of color. Among the AIDS cases diagnosed between January 1999 and December 2001, 81.2 percent were among people of color (including African-Americans, Hispanics, Native Americans and Asian/Pacific Islanders). HIV data for 2001 indicates increases in HIV disease among African Americans and Hispanics, women and youth. In 2001, among newly diagnosed HIV cases statewide, cases among African-Americans represented 52.3 percent, cases among Hispanics, 28.8 percent and cases among Whites, 17 percent. There was a greater proportion of females (38.8 percent) among the newly diagnosed HIV cases than among newly diagnosed AIDS cases (33.5 percent), and greater proportion of younger cases under 30 years of age (22.8 percent versus 10.4 percent).

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 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 manager 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. HIV infected persons;
2. HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; and
3. high risk individuals for a temporary period of time not to exceed 6 months with transition to another appropriate case management program for individuals who are HIV negative or continued unknown status. High risk individuals are those individuals who are members of the following categories:

    - Men who have sex with men (MSM), substance abusers, persons with history of sexually transmitted diseases, sex workers, bisexual individuals, sexually active adolescents engaging in unprotected sex, and persons who engage in unprotected sex with HIV+ or high risk individuals.
    - 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.
    - 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.

Family members and other collaterals of the above targeted index clients may also receive case management services as necessary, to allow for the provision of necessary care and services to the targeted individual. Services for case collaterals shall be considered as one family unit in the case manager's caseload. Separate assessments and service plans are not required for collaterals, but may be incorporated into the case records of the primary client. Collaterals may have services arranged for by the case management provider. Case management services for collaterals should be limited to issues that directly affect the care of and services to the primary client.

B. CFP Staffing Structure

The Team Model

The CFP utilizes a team approach to case management. Members of a "team" include a case manager, case management technician and a community follow-up worker. 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.

Reimbursement for "team" case management activities is only available for the case manager and the case management technician positions. However, costs associated with the community follow-up worker are included in the rate reimbursement structure.

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

- In metropolitan NYC, which includes the five boroughs of New York City and Nassau, Suffolk, Rockland, and Westchester Counties, the rate supports one community follow-up worker for each "team" of two billable FTEs. For upstate NY, the rate supports one community follow-up worker for every three billable FTEs or two community follow-up workers for every three teams.
- The rate reimbursement structure is based on a team composition of a case manager and case management technician as the billable staff. However, agencies may develop a team comprised of two case managers as the billable staff.

At least one community follow-up worker should be hired within twelve months of the provider's operational start date. Prior to moving to the next tier level, all CFWs in the approved work plan's staffing structure must be hired. (Tiers are described in depth in the Budget Section).

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 HIV infection, and/or persons with a history of mental illness, homelessness, or chemical dependence. 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 the second case management team is 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.

Case Manager (CM)
Minimum Qualifications:

> Master's or Bachelor's degree in health, human or education services, and one year of qualifying experience;
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> **OR**
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> Associate's degree in health or human services or certification as an R.N. or L.P.N. and two years of qualifying experience.

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.

Case Management Technician (CMT)
Minimum Qualifications:

Associates degree in health and human services and one year of qualifying experience;

OR

High School diploma or G.E.D., and two years of qualifying experience.

The CMT assists the case manager 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.

Community Follow-up Worker (CFW)
Minimum Qualifications:

Ability to read, write, understand and carry out directions. Community resident with knowledge of community resources and sensitivity towards persons with HIV preferred.

The CFW assists the CM and CMT 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. Engages in case finding activities such as 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. The standardized reimbursement rate includes an additional eleven training days per year for each billable staff. Providers must maintain a training log documenting the provision of training to all case management employees. This training log must indicate by employee, the type of training, who provided the training and record the time spent in each training. Training requirements can be met by in-service presentations or through formalized training workshops.

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 recommended training for all new case management staff within three months of employment:

- HIV epidemiology and health care
- HIV and TB
- HIV Confidentiality Law
- HIV prevention/risk reduction education
- Child Abuse and Neglect-Mandated Reporting

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
- 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 issues (e.g., domestic violence)
- stress/burnout reduction
- disclosure

If staff received related training during other employment, it should be verified and noted in the training log.

In addition to the training days, the reimbursement rate supports the costs for one-half of the case management staff to attend the NYSDOH/AIDS Institute Statewide HIV/AIDS Policy Conference. Programs are strongly encouraged to send staff to the statewide conference.

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 one 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.

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 non-compliant 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 follow-up status" should be approved by the CFP Program Director. 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. 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

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 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. A case manager may supervise no more than two staff members (CMTs or CFWs).

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 is forty-five.

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 A.

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
- 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.

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, billing instructions and pre-printed Medicaid claim forms. 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-specific supervisory review and case conferences are directly billable at the approved hourly 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 120 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, completing application forms, and/or writing letters on behalf of the client
- education to help clients understand the reason for a particular service and to help clients seek services on their own
- counseling 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
- time spent trying to locate enrolled CFP clients
- escorting 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. Billing for CMCM Services:

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 case manager 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

Example: 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. **Billing/Revenues/Expenses**:

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

Prior to January 1, 1994 the rate reimbursement method was based on provider specific rates. Each agency projected costs of personal service, indirect services as well as consultant, travel, equipment and supply costs. The total reimbursable costs were then divided by the annual billable case manager and case management technician hours to yield an hourly rate for case management activities. The time available for billable case management activities (billable hours) had to be at least 55% of total case manager and technician hours. The other 45% of non-billable time included activities such as leave time, training, meetings, and administrative/ documentation work.

Effective January 1, 1994, the provider specific reimbursement rate structure for the Community Follow-Up Program was replaced with the following:

- two regional rate schedules consisting of:
    1. Metropolitan New York (5 boroughs of New York City and Nassau, Suffolk, Rockland and Westchester Counties); and
    2. Upstate (all other counties in NYS)

- a three-tier rate structure within each region which reflects program size and accounts for economies of scale as programs become larger.

The standardized reimbursement rates were based on the identification of direct and indirect service components, the review of budget and cost information of operational providers, and the development of a 1993 cost based budget. This 1993 model budget was then trended by the US Department of Labor Statistics trend factor of 3.7% to account for projected 1994 costs. The rates have been trended periodically using the same source for the trend factor.

The most significant change in the new rate structure is the methodology used to calculate the total number of billable hours required to return the budgeted expenses to the agency. Although the 55% billable hour guideline remains a requirement, the calculation of total billable hours is based on a 230 day work-year rather than the previous 260 day work-year. The additional thirty day adjustment accounts for the following non-billable activities that are critical to the delivery of quality HIV case management services:

- staff support and bereavement services (18 days);
- skills development training (11 days); and,
- interagency networking/resource development (1 day).

As a result of this change, the annual billable time requirement for each FTE billable staff is reduced from 1001 hours to 885.5 hours or approximately twenty hours per week based on a thirty-five hour work week.

The specific rate accessed by each agency will be based on geographic location and the number of filled billable FTE's (CMs and CMTs) as of the program's operational start date. It is the provider's responsibility to notify the AIDS Institute Bureau of Community Support Services in writing of any staffing changes in order to determine if a rate change should be processed. In order to account for economics of scale for larger programs, rates are decreased slightly as the number of filled FTEs increases. The billable staffing levels and corresponding Tier and current rate are as follows;

NYC Metropolitan Rates:(Includes NYC, Nassau, Suffolk, Rockland, & Westchester Counties):

	HOURLY RATE	UNIT RATE
Tier 1: 1 – 6 billable FTE's	$104.84	$26.21
Tier 2: 7 – 12 billable FTE’s	$ 98.04	$24.51
Tier 3: more than 12 billable FTE’s	$ 95.84	$23.96

Rest of State:

	HOURLY RATE	UNIT RATE
Tier 1: 1 – 6 billable FTE's	$75.56	$18.89
Tier 2: 7 – 12 billable FTE’s	$72.04	$18.01
Tier 3: more than 12 billable FTE’s	$70.88	$17.72

The revised rate structure is driven by direct service costs and identified factors related to a 28% allowance for indirect costs. The direct and indirect costs are listed in Attachment D. Please note that indirect costs include non-direct personal service costs (personnel costs which are not directly related to case management service delivery such as secretary, billing clerk and administrative positions). Detailed line item budgets and justifications are no longer required in order to determine individual provider rates. However, a summary budget worksheet and brief line item description will be required as part of the application package. This will assist the agency with fiscal and program planning. It is also used by AIDS Institute for the purpose of assistance in reviewing your budget to determine if your expenditures are likely to be fully reimbursed under the rate structure. Please note that costs associated with direct client services

continue to be non-fundable and may not be included in your budget. (counseling, support groups etc.)

In order to develop a sound budget that will support the program, it is necessary to understand the assumptions which were used to develop the 1993 model budgets. These 1993 model budgets were subsequently trended to develop budgets and corresponding rates for subsequent years.

DIRECT COSTS

Personal Service Direct Costs

Salary and fringe rates were based on average costs for existing providers for the 1993 rate year.

50% of the Program Supervisor/Director costs were included under direct costs based on the assumption that 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.

Non Personal Service Direct Costs

These costs were based on approved budgets and costs for operational providers for the following categories: travel, crisis intervention, staff escort services, quality assurance (QA) costs. Training costs were included for all case management positions at a cost of $200 each. Conference registration costs were calculated at $200 per person for 50% of the case management staff.

INDIRECT COSTS

A 28% allowance for indirect costs was then applied to the total program costs for each tier in determining total projected program costs.

Attachment A outlines the costs used to develop the budgets for each of the tiers for the current rates. They should be used as a guideline in developing your program specific budget.