MEDICAL CASE MANAGEMENT SERVICE STANDARD

Service Category Definition (approved by SPA June 2021)

Medical Case management services, including treatment adherence, are a range of client centered services that link clients with health care. MCM's ensure timely and coordinated access to medically appropriate levels of health and support services with continuity of care, provided by trained professionals who are part of the clinical care team. Key activities of Medical Case Management are as follows: initial assessment of service needs, development of a comprehensive individualized service plan, coordination of services required to implement the plan, client monitoring to assess the efficacy of said plan and periodic reevaluation and adaptation of the plan as necessary over the life of the client. This includes utilization of services. Varying levels of case management such as face-to-face, phone contact and any other forms of communication.

Included in this is the Intensive Medical Case Management component: Intensive Medical Case Management utilizes all MAI funding and focuses on the EMAs priority populations; women of color, transgender women of color and men of color who have sex with men. The goal is to help clients re-enter or maintain medical care and other supportive services and to ultimately achieve viral suppression. IMCM teams develop care plans, enhancing life skills, address health and mental health/substance use needs, engage in meaningful activities and build social and community relations. It is designed for clients who are, newly diagnosed, returned to care, or not virally suppressed and who are identified as needing intensive support (higher acuity) for a shorter and time-delineated period.

Intake and Eligibility (HIV/AIDS BUREAU PCN #21-02)

For both initial/annual and six-month recertification procedures, eligibility determinations may be performed simultaneously with testing and treatment. Recipients and subrecipients assume the risk of recouping any HRSA RWHAP funds utilized for clients ultimately determined to be ineligible, and instead, charge an alternate payment source, or otherwise ensure that funds are returned to the HRSA RWHAP program.

REQUIRED ELIGIBILITY DOCUMENTATION TABLE

Eligibility Requirement	Initial Eligibility Determination	Recertification Once a Year/12 Month Period
HIV Status	Documentation required for Initial Eligibility Determination: • Confirmatory lab results • Lab results (including VL/CD4) • Lab request form signed by provider	No documentation required
Income	Documentation required for Initial Eligibility Determination: • Paystubs • SSI, SSDI and DSS income determination forms • Zero income affidavit • Bank Statement • Self-Employment Letter	• Recipient may choose to require a full applicationand associated documentation **OR** • Self-attestation of no change • Self-attestation of change - Recipient must require documentation of change in eligibility status

COLLABORATIVE RESEARCH

Residency	Documentation required for Initial Eligibility Determination: • Driver's License/ID • Utility Bill • Medical Bill • Bank Statement • Landlord Letter-Notarized • Copy of Lease/Mortgage • Letter from Shelter • Official Correspondence	• Recipient may choose to require a full applicationand associated documentation **OR** • Self-attestation of no change • Self-attestation of change - Recipient must require documentation of change in eligibility status

All agencies are required to have a client intake and eligibility policy on file that adheres to the EMA's eligibility policy. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A Eligibility Policy in accordance with HRSA/HAB regulations. Eligibility must be completed at least once every six months.

Eligible clients in the New Haven & Fairfield Counties EMA must:

- Live in New Haven or Fairfield Counties in Connecticut.
- Have a documented diagnosis of HIV/AIDS.
- Have a household income that is at or below 300% of the federal poverty level.

Services will be provided to all clients without discrimination based on: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, prior medical history, or any other basis prohibited by law.

Guidance on Complying with the Payor of Last Resort Requirement:

- RWHAP Recipients and Subrecipients must ensure that reasonable efforts are made to use non RWHAP resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify any other possible payors to extend finite RWHAP funds.
- RWHAP Recipients and Subrecipients must maintain policies and document their efforts to ensure that they assist clients to vigorously pursue enrollment in health care coverage and that clients have accessed all other available public and private funding sources for which they may be eligible.
- RWHAP Recipients and Subrecipients can continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage so long as there is rigorous documentation that such coverage was vigorously pursued.
- RWHAP Recipients and Subrecipients should conduct periodic checks to identify any potential changes to clients' healthcare coverage that may affect whether the RWHAP remains the payor of last resort and require clients to report any such changes.

Payor of Last Resort:

Once a client is eligible to receive RWHAP services, the RWHAP is considered the payor of last resort, and as such, funds may not be used for any item or service to the extent that payment has been made, or can reasonably be expected to be made under:

1. Any State compensation program
2. An insurance policy, or under any Federal or State health benefits program
3. An entity that provides health services on a pre-paid basis

Services will be provided to all Ryan White Part A eligible clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Personnel Qualifications (including licensure)

Provide written assurances and maintain documentation showing the medical case management services are provided by trained professionals with the following qualifications:

- A Bachelor's (preferred) in social work from an accredited program; OR
- An Associate degree (preferred) in health or human services field from an accredited program AND two years of paid experience will substitute for the degree; OR
- In lieu of a degree, four years of experience in human services
- Medical Case Managers must receive minimum training requirements per Parts A, B, C, D and participate in training as mandated by Parts A, B, C, D baseline for new MCMs and annually.

Care and Quality Improvement Outcome Goals

The overall treatment goal of medical case management is to provide care planning and coordination services needed for people living with HIV/AIDS, ensuring access to core and support services that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for Medical Case Management Services are:

- 90% of clients receiving medical case management services are actively engaged in medical care as documented by at least one medical visit in each 6-month period.
- 90% of clients are virally suppressed as evidenced by the last viral load test within the measurement year (<200 copies/mL) as documented in the reporting system

Service Standards and Goals

HRSA/HAB Performance Measure: Viral Suppression (NQF#: 2082)		GOAL
STANDARD/MEASURE	**AGENCY RESPONSIBILITY**	
Clients are virally suppressed.	Documentation that the client is virally suppressed within as evidenced by the last viral load test within the measurement year (<200 copies/mL) as documented in the reporting system.	90%
HRSA/HAB Performance Measure: Gap in HIV Medical Visits		

STANDARD/MEASURE	AGENCY RESPONSIBILITY	
Client with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	Documentation of medical visit history evident in client chart.	90%
HRSA/HAB Performance Measure: HIV Medical Visit Frequency		
STANDARD/MEASURE	**AGENCY RESPONSIBILITY**	
Documentation that the client who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.	Documentation of medical visit history evident in client chart.	90%
HRSA/HAB National Program Monitoring Standards for RWHAP Part A: Section B: Core Medical Services		
STANDARD/MEASURE	**AGENCY RESPONSIBILITY**	
Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team.	Provide written assurances and maintain documentation showing that medical case management services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team.	100%
New medical case management clients receive an initial assessment within five (5) business days of enrollment/intake.	Documentation of initial assessment is completed within five (5) business days and is included in the client chart for the measurement year.	
Clients have a completed comprehensive individual care plan within ten (10) business days of initial assessment.	Documentation of completed comprehensive individual care plan within ten (10) business days and is included in the client chart for the measurement year.	
Clients receive coordinated referrals and information for services required to implement the care plan.	Documentation of referrals and service coordination are noted in the client chart in the measurement year.	
Clients are continuously monitored to assess the efficacy of their individual care plan.	Documentation of continuous monitoring to assess the efficacy of the care plan is evident in the client chart/progress notes, etc.	
Case managers are documenting types of services provided, types of encounters/communication, duration, and frequency of the encounters.	Maintain client records that include the required elements for compliance with contractual and Ryan White programmatic requirements, including required case management activities such as services and activities, the type of contact, and the duration and frequency of the encounter.	100%

	Document client services provided, such as: Client-centered services that link clients with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible. Also include coordination and follow up of medical treatments, ongoing assessment of client's and other key family members' needs and personal support systems such as treatment adherence counseling and client-specific advocacy.		
	New Haven/Fairfield Counties EMA RWHAP Part A Program Monitoring Standards for Medical Case Management services.		
	STANDARD/MEASURE	**AGENCY RESPONSIBILITY**	
	All Ryan White services not covered by Title XIX or another medical insurer must have documentation to indicate the service(s) provided are not allowable under the health plan.	Maintain documentation showing all Ryan White services not covered by Title XIX or another medical insurer must have documentation to indicate the service(s) provided are not allowable under the health plan.	100%
	Define role expectations and tasks of the MCM with signed job descriptions clearly defining roles of staff members with HIPAA acknowledgement forms signed in MCM HR file.	Maintain documentation showing defined role expectations and tasks of the MCM with signed job descriptions clearly defining roles of staff members with HIPAA acknowledgement forms signed in MCM HR file.	100%
	New MCM clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year as documented in the reporting system.	90%
	Clients will have an acuity scale completed and documented, reflecting their current acuity level.	Documentation of acuity scale is included in the chart of all clients in the measurement year.	100%
	Clients have their individual care plans updated two or more times, at least three months apart.	Documentation that the individual care plan is updated two or more times, at least three months apart.	90%
	Case closure protocol	Documentation that agency followed case closure protocol.	100%
	A discharge summary (for all reasons) must be placed in each client's chart within 72 hours of discharge.	Closed charts will contain a discharge summary and of those closed charts will have a documented a summary within 72 hours of discharge.	90%

	Clients lost to care have documented attempts of contact prior to case closure.	If client is "lost-to-care" (cannot be located), the agency will: • Make and document a minimum of 3 follow-up attempts over a 3-month period after first attempt. • A certified letter must be mailed to the client's last known mailing address within five business days after the last phone attempt notifying the client of pending inactivation within 30 days from the date on the letter if the client does not make an appointment to rescreen.	100%

Clients Rights and Responsibilities

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer fully understands their rights and responsibilities.

Client Charts, Privacy, and Confidentiality

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of the client's Personal Health Information (PHI). Agencies must have a client's release of information policy in place and review the release regulations with the client before services are provided. A signed copy of the client's release of information must be included in the client's chart.

Cultural and Linguistic Competency

Agencies providing services must adhere to the National Standards on Culturally and Linguistically Appropriate Services. (Please see https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53 for more information)

Client Grievance Process

Each agency must have a written grievance procedure policy. Clients will be informed and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of receipt of the grievance procedure policy form must be included in the client's chart.

Case Closure Protocol

Each agency providing services will have a case closure protocol. The reason for case closure must be properly documented in each client's chart.