

# **HIV CARE & TREATMENT PROGRAM**

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## **STATE MANAGED SERVICES PROGRAM POLICIES & PROCEDURES**



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## State Managed Services Program (SMS)– Policies and Procedures

New Name!

The Department of Human Services (DHS), Public Health, HIV Care and Treatment Program (Program) administers the HIV Case Management and Support Services Program funded by Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program, Part B).

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

Name of Policy and/or Procedure: **Eligibility**  
Effective Date: **July 1, 2004**  
Purpose: Defines who is eligible and who determines eligibility.

### ***Policy***

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The State Managed Services Program will not be responsible for determining client eligibility. Clients of the SMS program are determined to be eligible by the HIV Case Manager in accordance with the requirements outlined in the *HIV Case Management and Support Services Program, Program Policies, Services Definitions and Guidance*. Submission of a SMS request form verifies HIV status and income eligibility for the program.

Name of Policy and/or Procedure: **Request Form Process**  
Effective Date: **July 1, 2004**  
Purpose: Defines what is needed to process the request

### ***Policy***

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SMS requests must be made by a trained State of Oregon, HIV Case Management and Support Services Program, HIV Case Manager (CM) 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 Dental Services 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.

**Revised!**

### ***Procedure***

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The Request Form must be complete and submitted via confidential fax to the SMS-Payment Processor (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 Dental Services, the request form is faxed for authorization of the initial assessment only. The service will not be authorized until the program receives the service/treatment plan. In this case, the case manager will complete two request forms (one for the assessment, and then one for the service).

All providers must be pre-authorized by the SMS-Payment Processor, including additional providers or referral to another provider by the originally authorized provider. The CM must send the SMS-Payment Processor 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 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**

**Effective Date: July 1, 2007**

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

### ***Policy:***

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

1. Dental Services
2. Mental Health Treatment (Outpatient or Inpatient)
3. Substance Abuse Treatment (Outpatient or Inpatient)
4. Home Health Services

The approved Service Plan form must be used for mental health and substance abuse service requests. The Service Plan form cannot be used for Dental Services. Only a treatment plan provided by the dentist will be accepted.

Name of Policy and/or Procedure: <b>Authorization/Denial Process</b> Effective Date: <b>July 1, 2007</b> Purpose: Describes authorization and denial of a request.
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***Policy:***

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Within two business days of receiving a complete application (all Dental, Mental Health, Substance Abuse and Home Health Service requests must include a service/treatment plan), the CM will receive 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). **SMS funds, as are all Ryan White funds, are the payer of last resort.**
- There appears to be a conflict of interest.



New!

***Procedure:***

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1. SMS-Payment Processor 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. Incomplete Request Form's will be faxed back with a "Request for Additional Information" form attached.
3. SMS-Payment Processor reviews 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 SMS-Payment Processor will fax a Funding Authorization form to the CM (either denying or approving).

Name of Policy and/or Procedure: **Authorization Expiration**  
Effective Date: **July 1, 2004**  
Purpose: Defines expiration of authorizations.

***Policy:***

Authorizations will expire on June 30<sup>th</sup> of each year. HIV Case Managers will receive a 30-day notice from the Fiscal Coordinator that all active client files will expire on June 30<sup>th</sup>. The CM must submit a new Request Form to continue services into the next service year (beginning on July 1<sup>st</sup> of each year). Clients will receive a new full services award on July 1<sup>st</sup>. Funding carry-over from one year to the next is not allowed.

***Procedure:***

1. By May 15<sup>th</sup>, the Fiscal Coordinator will send a "Service Expiration Letter" to all CM who have an active client in the SMS program.
2. By July 1<sup>st</sup>, all previously authorized clients will be inactivated. To continue activation, the CM must submit a new Request Form and service/treatment plan if requesting Mental Health, Substance Abuse, Home Health or Dental services.

Name of Policy and/or Procedure: **Service Utilization**  
Effective Date: **July 1, 2004**  
Purpose: Defines requirement for service utilization.

***Policy:***

**Revised!**

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-Payment Processor will cancel the service authorization and a notice will be sent to the case manager.

Name of Policy and/or Procedure: **Data Entry**  
Effective Date: **July 1, 2007**  
Purpose: Defines data entry requirements.

***Policy:***

SMS data will be collected in the Care Assist database.

**Procedure:**

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The SMS-Payment Processor will enter the following information into the Care Assist database:

- Client demographics (name, address, gender, race, ethnicity, date of birth) – if the client is already a Care Assist client then this information would need to be checked for accuracy.
- County of Residence– if the client is already a Care Assist 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 Care Assist 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 30<sup>th</sup>)

Name of Policy and/or Procedure: **Billing**  
Effective Date: **July 1, 2007**  
Purpose: Defines billing requirements.

**Policy:**

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- Invoices must be submitted to the SMS-Payment Processor 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.
- All services must be completed by June 30<sup>th</sup> of the program year.

**Revised!**

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:**

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If a vendor bills past the 90 day requirement the SMS program will send a notice informing the case manager that the authorization for services has been cancelled. If the service did begin during that timeframe and an invoice is received after cancellation

**Revised!**

the Fiscal Coordinator will authorize payment for the first offense. The program will not be responsible for paying after the second offense.

Name of Policy and/or Procedure: **Insurance Policy**

Effective Date: **July 1, 2004**

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

***Policy:***

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If the client has an insurance policy the CM 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.

The Ryan White Program funds are the funds of last resort.

Name of Policy and/or Procedure: **Service Funding Limits**

Effective Date: **July 1, 2007**

Purpose: Defines service funding caps.

***Policy:***

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

- Dental Services (Recommended maximum benefit is \$1000 per year per client)
- Home Health Care- Paraprofessional, Professional, Specialized (Maximum benefit is \$2000 per client per year)
- Mental Health Treatment/Therapy or Counseling- Outpatient or Inpatient Therapy (Total Maximum Benefit is \$6500 per client per year)
- Substance Abuse Treatment (Total Maximum Benefit is \$5000 per client per year for all Substance Abuse Treatment services)

**Revised!**

Name of Policy and/or Procedure: **Program Exceptions**

Effective Date: **July 1, 2006**

Purpose: Defines program exceptions.

***Policy:***

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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**

Effective Date: **July 1, 2007**

Purpose: Describes the process that occurs when a client completes the authorized service.

***Policy:***

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Case managers 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 then the program will reallocate those encumbered funds back into the SMS program with the exception of Dental Services (remaining funds will be placed back into the county's funding allocation for the year).

A client may only be approved for an SMS service once per year, therefore case managers cannot re-apply on behalf of the client for the same service after closing the service file.

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.



**New!**

***Procedure:***

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Step #1: The Fiscal Coordinator will run a State Managed Services Summary Report every month.

Step #2: The Fiscal Coordinator will identify services that appear to be completed and provide a report to the SMS-Payment Processor.

Step #3: The SMS-Payment Processor will call the case manager to receive oral verification regarding the service in question. If the case manager confirms that the services have been completed the SMS-Payment Processor will continue to Step #4.

Step #4: The SMS-Payment Processor will complete the "Services Completed" form.

Step #5: The SMS-Payment Processor will attach the completed form to an email to the case manager, including a "cc" to the Fiscal Coordinator.

Name of Policy and/or Procedure: **Conflict of Interest**

Effective Date: **July 1, 2005**

Purpose: Defines the "conflict of interest" policy.

***Policy:***

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

1. HIV Case Managers 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. HIV Case Managers 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. HIV Case Managers may not use information about a client or patient that was gained during employment funded by the local HIV Case Management and Support Services Program to further the employee's personal gain.

Name of Policy and/or Procedure: **Allocation of Funds**

Effective Date: **July 1, 2004**

Purpose: Describes amount of service available to each county.

***Policy:***

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The HIV Case Management and Support Service Program will determine the dollar amount for each SMS service in June of each year based on dollars available, current client utilization data and recommendations made by the Oregon HIV Care Coalition. The Fiscal Coordinator 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 will receive a Dental Services funding allocation on July 1st of the service year. The allocation will be determined using the approved Coalition of Local Health Officials (CLHO) formula for calculation of funds distribution. No HIV Case Management and Support Services funded county will receive less than \$1,000.

It is strongly recommended that case managers follow the "Maximum Allowable" guidelines set by the Program to determine appropriate service expenditures per client per Fiscal Year. However, case managers will be responsible for assessing client needs and can request more than the recommended \$1000 for a client who has extensive dental needs (for dental only!). All requests will be pulled from the agency's Dental Services Funding Allocation, and requesting additional funds for one client will reduce the number of available funds for all clients in that county. All dental requests must be accompanied by a dental service plan and include the total amount that will be invoiced.

When a request for dental service exceeds the \$1000/per client recommended funding amount, the SMS-Payment Processor will make contact with the requesting case manager to assure that the case manager understands this process before a Funding Authorization Form is sent.

<p>Name of Policy and/or Procedure: <b>Reallocation of Funds</b> Effective Date: <b>July 1, 2004</b> Purpose: Defines reallocation of service funds.</p>
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***Policy:***

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The Program may re-allocate funds depending on services utilization. The Fiscal Coordinator will review the use of funds and services utilization at 3 months, 6 months and 9 months of the Fiscal Year.

***Procedure:***

Reallocation Process to Other SMS services:  
The Fiscal Coordinator will review the utilization of each service under the SMS program at 3, 6 and 9 months. The Fiscal Coordinator will move funds from under-utilized services to higher-utilized services. This process may differ depending on current data and information provided by all agencies.