ILLINOIS RYAN WHITE PART B CASE MANAGEMENT

Module 4

Enrollment and Eligibility Activities

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ACUITY SCALE

INTAKE ACTIVITIES

Case Management Acuity Scale

Purpose: To establish the level of Case Management and frequency of contact to be provided.

- The Program has developed the Case Management Acuity Scale to assist intake staff in determining the appropriate form of case management for the program participant.
- This document should be completed before the Eligibility Assessment (EA) so that the program participant can be connected with the appropriate case manager as soon as possible.
- If a form of case management is indicated that the individual conducting the intake is not able to provide, the program participant must be provided a “warm” transition to the appropriate Case Manager.
- In order to prevent any delay in services, intake staff may complete the Eligibility Assessment in instances when the indicated case manager is unavailable but all effort should be made to connect program participant with the indicated case manager first.
- The Acuity Scale must be completed for each program participant at every eligibility determination or when a change in circumstances dictates further review of program participant need.

INTAKE ACTIVITIES

- A series of YES/NO questions was designed to distinguish program participant characteristics that indicate the highest needs. An answer of “Yes” to any of these questions requires that the client is enrolled into a form of Medical Case Management and not Non-Medical Case Management.
- A table then determines the level of acuity with categories commonly related to HIV services, as well as a Likert-like scale to rate the program participant’s level of need in each category.
- Case Manager scores program participant on topics relating to program participant health or access.
- The ratings start at 0 (no need, self-sufficient) to 3 (high need, likely to need intensive services).
- Examples are given in each category to assist in rating the level of need and also provide a standard definition of need.
- Scores of two (2) or three (3) in Mental Health or Substance Use indicate automatic enrollment into a form of Medical Case Management.

INTAKE ACTIVITIES

- The total acuity score is automatically calculated to provide the Case Manager with an indication of overall need.
- **Type of Case Management Needed is then determined.**
  - The Case Manager will choose one of the four types of case management.
  - Based on the needs score, the program participant should be enrolled into the appropriate type of case management.
  - A program participant may be placed in a more intensive form of case management but not a less restrictive type.
- **Required Level of Interaction defines contacts and frequency.**
  - A text box is used to describe how often the program participant agrees to be contacted, method of contact, and reasoning behind the schedule.
  - No set number of contacts is required.
  - Case managers may indicate type(s) of contact the program participant prefers.

INTAKE ACTIVITIES

Monitoring

- Was the form completed at each eligibility determination?
- Was the information entered within 5 business days of the CM intake session?
- Was the type of Case Management and level of interaction listed consistent with the documentation in the data system (Progress Logs, Care Plan, etc.)?
- Did the level of interaction describe the frequency of future interactions?
- Did the level of interaction describe the type(s) of contact the program participant was agreeable to?
- Was justification provided for any discrepancies in scoring, type of Case Management chosen, or program participant interaction?

QUESTIONS

If you have any questions on the content of this presentation, please write them down and bring them to the regional webinars provided by the Program.

The Program is committed to addressing your questions and feedback during these follow up meetings.

Thank you for your participation.

ELIGIBILITY ASSESSMENT

ELIGIBILITY ASSESSMENT

In order to be deemed eligible for the Program, applicants must complete an Eligibility Assessment. This assessment will then be reviewed by a Program and/or Lead Agency staff member who will render a decision on eligibility.

- Allows the Program to collect all necessary and required information to document and determine eligibility.
- Allows the program participant to specify which services may be needed.
- Can be submitted by the CM or by the program participant themselves through the online portal.
- Requires several pieces of documentation and Program forms signed and dated by program participant.
- Can be approved by CM and/or IDPH staff depending on services requested.
- Program participants may receive CARE services while awaiting MAP/PAP approval.

The Eligibility Assessment can be completed in three ways.

- Online via Web User Account
- Online without Web User Account
- Case Manager

ELIGIBILITY ASSESSMENT

Online Submission

The Program has provided program participants with the ability to complete the Eligibility Assessment online.

https://iladap.providecm.net/

All required supporting documentation can be obtained online as well.

https://iladap.providecm.net/home/docs

ELIGIBILITY ASSESSMENT

Web User Account - highly recommended

The Program has provided program participants with the ability to complete the Eligibility Assessment online using a Web User Account. The benefits of this are the client can log in at each enrollment, track its progress, and sign up to receive text and/or email notifications from the program about their eligibility.

To request an account, program participants must sign and date the Web User Account Agreement and then schedule an appointment to meet face to face with a funded case management provider in their jurisdiction.

https://iladap.providecm.net/Content/docs/WebUserAccountAgreement.pdf

The signed agreement must be brought to the appointment, along with photo identification, so the provider can verify the individual's identity.

ELIGIBILITY ASSESSMENT

Case Manager Submission

Program participants can work with any funded case management provider within their jurisdiction to complete the Eligibility Assessment directly within the data system.

Case Managers are required to assist program participants with this even if the only service the individual needs is Medication and/or Premium Assistance.

Case Managers must only use the data system to submit Eligibility Assessments for program participants.

ELIGIBILITY ASSESSMENT

Required Documentation

- Authorization for Release of Health Information/Notice of Privacy Practices (NEW)
- Proof of HIV (required only once for each program participant)
- Lab Results
- Proof of Residency
- Proof of Income and Household Income Statement
- Insurance Coverage Documentation
- Premium Documentation (if requesting Premium Assistance)
- Affidavit of No Insurance (if client is uninsured or underinsured)

ELIGIBILITY ASSESSMENT

Required Documentation Instructions

In general, documentation required for Eligibility Assessments should follow these instructions.

- The most recent version of the forms is required.
- All demographic information should be included in the top section to allow for proper program participant identification.
- Social Security Numbers are not required for program participants who do not have them.
- The signature and date on each form must be within 90 days of the submission of the EA.
- All forms must be completed at intake and at every eligibility determination.
- In general, all pages should be scanned into the EA.
- Instructions to complete the EA can be found at:
  - https://iladap.providecm.net/Content/docs/EligibilityAssessmentWebsiteInstructionManual.pdf

ELIGIBILITY ASSESSMENT

Authorization to Release Health Information/Notice of Privacy Practices

- This form serves as the program participant's agreement to participate in the Program and allow the Program to collect, store, and share their information with the entities listed on the form for the purposes of coordination of care, treatment, and payment of services.
  - Examples are case managers, benefit specialists, program participant's medical team, subcontractors/sub-recipients/sub-grantees, other entities that assist with enrollment, other RWPB Parts, and IDPH-authorized outreach providers.
  - Program participant may add two individuals with whom the Program can share information.
- This form also provides information about the duties and privacy practices of the Illinois Ryan White Part B Program to protect the privacy of your personal health information.
- The form describes how IDPH may use and disclose program participants' health information.

ELIGIBILITY ASSESSMENT

Proof of HIV Documentation

- Documentation of HIV is only required once.
  - It must clearly identify program participant as the person with diagnosis.
- Acceptable documentation includes one of:
  - Confirmatory 4th generation, Western Blot, or Immunofluorescence Assay test result
  - Positive HIV RNA PCR
  - Positive DNA PCR assay
  - Detectable HIV Viral Load test result
  - Physician Affidavit that confirms the HIV diagnosis
    - Letter on official letterhead, printout of provider's EMR, or copy/printout of a medical chart note, that contains provider name and medical facility, if applicable.
    - Must clearly identify person being verified.
    - Must be signed by physician (or their designee) and dated.

ELIGIBILITY ASSESSMENT

Lab Results

- Viral Load lab results must have date of collection within six months prior to the submission of the Eligibility Assessment.
  - CD-4 lab results are recommended but not required.
- The documentation must clearly identify the program participant as the person tested.
- Lab reports must be provided at every eligibility determination.
- Documentation may be a paper copy of test result or an electronic transmission of a result from a lab or provider.
- Clients without a viral load drawn within the last six months can be approved conditionally for 90 days provided that their previous EA was not conditionally approved for the same reason.

ELIGIBILITY ASSESSMENT

Proof of Residency

- The program participant must be a resident of Illinois.
- Program participant's name and address listed on the residency document must match the name and address listed in the EA.
- If no acceptable form of residency documentation is available, complete the **Verification of Residency Form**.
  - **This form should be used only as a last resort!**
- Residency documentation is still required for homeless and transitional incarcerated program participants.
  - Indicate "Homeless" or address of shelter or correctional facility in Illinois as the address on the Verification of Residency Form. Please do not use a PO Box, agency address, etc. on the form if they are not living at that address.
- The signature and date by the program participant and case manager or shelter staff must be within 90 days of the submission of EA.

ELIGIBILITY ASSESSMENT

Acceptable Proof of Residency Documentation

- Lease or mortgage agreement
- Pay stub
- Bank or benefit statement
- Credit card statement
- Utility or phone bill
- Mail or letter not sent by any Ryan White Part B Program unit
- Current year tax return

✓ **Proof documents must be dated within 90 days of the submission of the EA, unless using lease/mortgage documents, which may be annual or older documents.**

✓ **Use of Driver's License or state issued ID will not be accepted after July 1, 2020.**

ELIGIBILITY ASSESSMENT

Proof of Income

- Current household income must be at or below 500% of the current Federal Poverty Level (FPL) to receive any service other than Medical or Non-Medical Case Management.
- The Modified Adjusted Gross Income (MAGI) is used for eligibility determinations.
- Housing assistance also uses an area median income (AMI) for eligibility.
- A ***Household Income Statement*** (HIS) must be completed for the program participant and each legal household member over age 18, even for individuals who have no income.
- Income must be documented for program participant and each legal household member over age 18.
- Supporting documentation for the program participant's and each legal household member's income must be dated within 90 days of the submission of the EA.

ELIGIBILITY ASSESSMENT

Proof of Income

Eligible household member is defined as the program participant and anyone who has a legal relationship to the program participant, including:

- Biological child under the age of 18 who lives in the residence,
- Biological child age 18-26 currently enrolled in higher learning institution (college or trade school), even if not living with program participant,
- Biological child over age 18 who receives Social Security Disability Income (SSDI) and lives in the residence,
- Individual related to the program participant as a result of a union that is legally recognized in Illinois, and
- Individuals related to the program participant because of a legal guardianship (typically an incapacitated senior, minor, or adult who is developmentally disabled) or adoption and lives in the residence.

✓ **Requests for additional documentation, with regards to household members and their income, are at the Program's discretion, and clients should be ready and able to provide this if asked.**

ELIGIBILITY ASSESSMENT

Household Income Statement

- Each eligible household member must be listed on the form, even if the household member does not have any income.
- Page 2 can be copied as many times as needed to list each **eligible** household member.
- The Household Income Statement must list all current, monthly income for program participant and each **eligible** household member.
  - Supporting documentation for any income amount greater than $0.00 on a **Bold** / asterisk (*) line is required.
  - Supporting documentation must match the amount listed on the form.
- The Household Income Statement is still required for any program participant or **eligible** household member who has no income.

✓ **In this situation, $0.00 must be listed on all income lines.**

ELIGIBILITY ASSESSMENT

Acceptable Proof of Income Documentation

- Two Pay Stubs – dated within 90 days (preferably the most recent two)
- Alimony Received – dated within 90 days
- IRA Distributions – dated within 90 days
- Pensions (Private/Employer/Veteran) – most recent year letter
- Disability (Private/Employer/Veteran's) – most recent year letter
- Unemployment Documentation – dated within 90 days
- SSA (Retirement) or SSDI (Disability) – most recent year award letter
- Jury Duty Pay – dated within 90 days
- Self Employment or Business Income – most recent monthly bank statement

✓ **These are the most commonly submitted income documents, but other acceptable forms of income documentation exist. All must clearly display the client's name and date of issuance.**

ELIGIBILITY ASSESSMENT

Proof of Income – Taxes

Program participants who enroll in both a health insurance marketplace plan and the Premium Assistance Program must file their federal tax returns.

The following pages must be supplied to the Program:

- 1040 form – Pages 1 and 2 *(Required for EA Approval)*
- Schedule 2 *(Required for EA Approval)*
- Schedule 3 *(Required for EA Approval)*
- Schedule 1 (if claiming business income or deductions) *(Not required for EA Approval)*
- IRS form 1095A (form mailed to the program participant from the Illinois Marketplace for use when filing their tax returns) *(Not required for EA Approval)*
- IRS Form 8962 (form generated as part of the tax return after properly answering the Marketplace Insurance sections on a tax return) *(Not required for EA Approval)*

ELIGIBILITY ASSESSMENT

- **Schedule 1, Additional Taxes and Adjustments to Income**
  - This schedule reports income or adjustments to income that cannot be entered directly on Form 1040, like capital gains, unemployment pay, prize money, and gambling winnings, as well as student loan interest deductions, self-employment tax, or educator expenses.
- **Schedule 2, Additional Tax (Schedules 2 and 4 were combined for 2019)**
  - This scheduled is used by taxpayers in specific situations. Those who owe alternative minimum tax or need to make an excess advance premium tax credit repayment will file this schedule.
- **Schedule 3, Other Payments and Refundable Credits (Schedules 3 and 5 were combined for 2019)**
  - Taxpayers who claim specific refundable credits or have other payments withheld will file this schedule. These other payments include:
    - Payment of the Net Premium Tax Credit,
    - Payment made when the taxpayer requests an extension, and
    - Payment of excess social security.

ELIGIBILITY ASSESSMENT

Tax Reconciliation

- If a program participant was enrolled in Premium Assistance, with a Marketplace Plan for the previous year, program participants **must** reconcile receipt of their Advance Premium Tax Credit. Please note: this must be done even if the client did not have an APTC on their policy for the previous year, as this process can determine if they should have.
- If proper documentation is not submitted, the program participant's enrollment will be held up.
- Did the program participant enroll in a Marketplace Plan in 2019?
  - ▫ No – we do not need the program participant's tax return.
  - ✓ Yes – we need the tax return.
- Is there a value on line 12b, page 2, of the federal 1040?
  - ✓ Yes – we will need Schedule 2.
- Is there a value on line 13b, page 2, of the federal 1040?
  - ✓ Yes – we will need Schedule 3.

ELIGIBILITY ASSESSMENT

Tax Reconciliation

- While the Program may make payments towards a program participant's Excess Premium Tax Credit, this repayment is at the discretion of the Program and is subject to change at any time. Eligibility should not be held up for information pertaining to repayment of the Excess Premium Tax Credit.
  - This information is contained on line 12b and schedule 2.
- The Program will, however, hold up Eligibility for information regarding receipt of the Net Premium Tax Credit.
  - This information is contained on line 13b and schedule 3.
  - The Program will not move any Eligibility forward until a determination can be made regarding whether or not the program participant owes a refund to the Program.

ELIGIBILITY ASSESSMENT

Insurance Coverage Documentation

Acceptable documentation of insurance coverage must be provided at every eligibility determination.

- Copies of insurance cards, front and back, for any plan are required.
- Examples are Medicare, Supplemental, Marketplace, Employer Based, Private, COBRA, Dental, Vision, Secondary, etc. Medicaid cards are not required, but encouraged if available.

Program participants must complete the **Affidavit of No Insurance** form if they:

- Do not have insurance coverage,
- Have insurance, but the plan does not have prescription drug coverage, or
- Have insurance, but the plan does not consider the IDPH's dispensing pharmacy to be in-network.

✓ Insurance cards that do not have a Rx Bin or Bin number, may indicate that the insurance plan has separate prescription cards. In this case, the prescription cards must also be provided. Clients need to contact their HR representative or carrier to verify this before submitting an Affidavit of No Insurance.

ELIGIBILITY ASSESSMENT

Premium Documentation

- Documentation of insurance premium is only required if program participant requests premium assistance.
- The insurance plan must accept 3rd party payments.
- Documentation of the premium must include:
  - Program participant name,
  - Plan name and metal level,
  - Premium amount,
  - Payment frequency, and
  - Mailing address for sending payment.
    - This is often different from addresses listed in the headers of letters and/or administrative headquarters.

ELIGIBILITY ASSESSMENT

COBRA and Premium Assistance Program

The Program will pay for COBRA plans only if the program participant meets all of the following requirements:

- Program participant is newly enrolled in the IL ADAP program.
- Program participant is outside of a Special Enrollment period for the ACA Marketplace.
- Program participant has been enrolled in the COBRA plan for 60 or more days.
- The COBRA plan meets all other Premium Assistance Program requirements.

ELIGIBILITY ASSESSMENT

Employer Plans and Premium Assistance Program

- In order to be eligible for Premium Assistance, employer-based plans must meet all previously mentioned PAP criteria.
- It is important to note that the Program must send the payment directly to the insurance company (BCBS, etc).
  - The Program cannot send payment to the program participant or the program participant's place of employment.
  - If this procedure cannot be arranged, the program participant's plan is not eligible for Premium Assistance.

ELIGIBILITY ASSESSMENT

Frequency and Expiration

- EAs must be completed every 6 months.
  - Enrollment periods will be the remainder of the month a new program participant is approved, plus an additional 5 months.
  - Conditional 90-day approval will be extended to the full enrollment timeframe upon receipt of all missing documents.
- If a completed assessment is not approved prior to the expiration of the current enrollment, any service the program participant receives after the expiration will be considered unallowable.
  - An unallowable designation results in your agency paying for the service without being reimbursed by IDPH.
- If the program participant is also enrolled in MAP or PAP, the completed EA (including all supporting documentation) must be submitted no later than 3 business days prior to the end of the month to allow time for processing.

ELIGIBILITY ASSESSMENT

Steps for Eligibility Determination

- The EA can be submitted online or through the Program's data system.
  - ✓ https://iladap.providecm.net/
- For MAP and/or PAP services only, the EA is routed to IDPH for approval.
- For Care services, EA must be submitted by agency and marked "Complete."
- Once Care services are authorized by the agency, the EA is then routed to IDPH if program participant requests MAP and/or PAP.

ELIGIBILITY ASSESSMENT

Monitoring Information

- Did documentation for Eligibility Assessment meet all requirements?
  - Date parameters, signatures, most recent forms, income documents for all legal household members, etc.
- Was information entered correctly into Eligibility Assessment?
  - Income amounts entered correctly, health coverage entered into the correct place, household contacts updated correctly, etc.
- Was Verification of Residency form used correctly?
- What was timeframe to re-send correct documents?
- What type of EA was submitted?
  - Priority reassessment, reassessment, reengagement, new assessment
  - Frequency of program participant closure

QUESTIONS

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Thank you for your participation.

INDIVIDUALIZED CARE PLAN

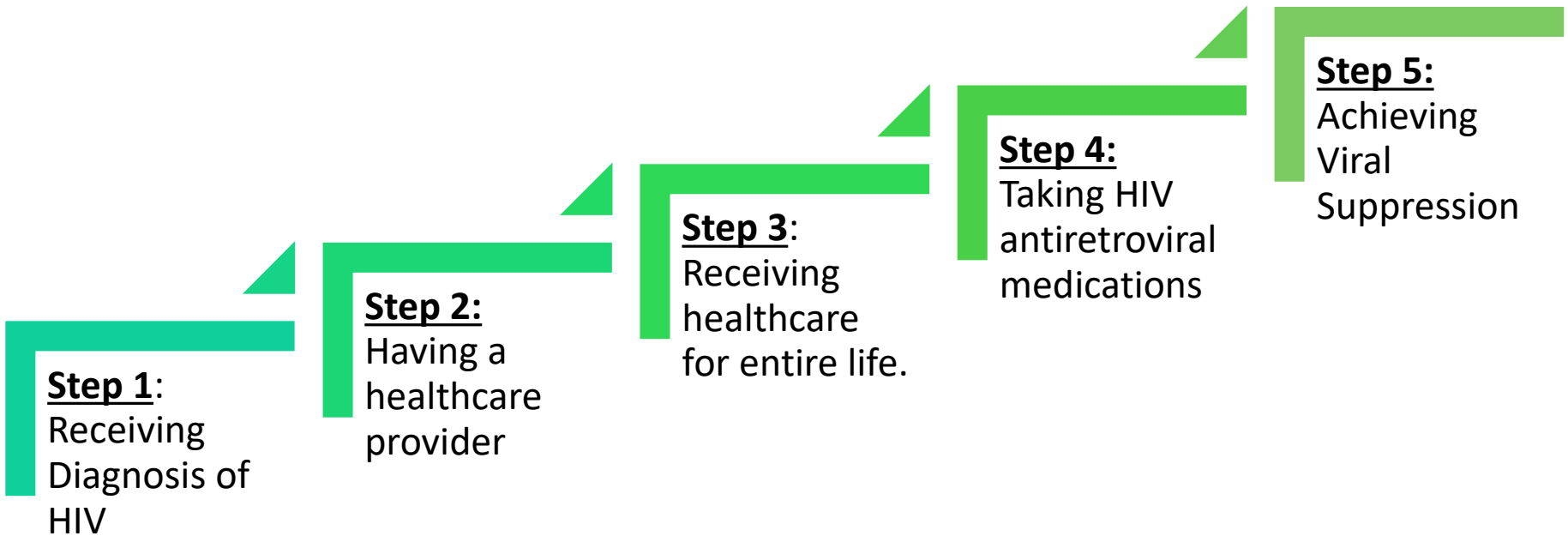
INDIVIDUALIZED CARE PLAN

Purpose: To provide a clear and detailed plan of action that addresses barriers to improving or maintaining good overall health status for the program participant.

- Involves a comprehensive dialogue with the program participant to thoroughly discuss any unmet needs or barrier(s) to medical or treatment compliance.
- Includes description of specific services/referrals to be provided to help overcome the barrier(s).
- Not required for Non-Medical Case Management

INDIVIDUALIZED CARE PLAN

Considerations



INDIVIDUALIZED CARE PLAN

Client Meeting and Discussion

Examine program participant's HIV health and medical compliance.

- Is program participant virally suppressed?
- Is program participant compliant with HIV medications?
- Does program participant have a medical/dental provider?
- Is program participant compliant with medical/dental appointments?
- Does program participant have health/dental insurance?
- Does program participant have history of mental health issues or substance abuse?
- Did program participant identify other potential health issues?

INDIVIDUALIZED CARE PLAN

Meeting Preparation

Examine other issues affecting the program participant that may be contributing to health issues or medical compliance.

- Does program participant have stable housing?
- Does program participant have transportation issues that prevent attending medical or other appointments?
- Is program participant able to secure adequate diet and nutrition?
- Does program participant experience intimate partner issues?
- Is program participant interested in counseling or support groups?
- Did program participant identify other potential issues?

INDIVIDUALIZED CARE PLAN

Program Participant Involvement

- Case Management is a program participant-oriented service.
- Program participants should always be involved in the discussion about individual barriers to care and ways to overcome barriers.
- When writing the Individualized Care Plan, use wording program participants will understand.
- Program participants should be aware of and agree to their responsibilities in the Individualized Care Plan.
- CM and program participant must sign the Individualized Care Plan.
- CM should scan signed copy into program participant profile in the data system.
- CM should give a paper copy to the program participant.

INDIVIDUALIZED CARE PLAN – DEPARTMENT MONITORING

- Is entry date within five (5) business days of creation?
- Does information contained in the plan match information from Acuity Scale and Progress Logs?
- If applicable, were assurances documented that emergent needs were immediately addressed?
- Does Progress Log describe a comprehensive interaction with the program participant about needs, barriers, and all services that the program participant received during the visit?
- Are indicated services or referrals based on program participant need?

INDIVIDUALIZED CARE PLAN – DEPARTMENT MONITORING

- Did the services provided or referrals made adequately address the program participant's needs and barriers?
- Are any changes in service needs in relation to viral suppression or treatment/medication adherence described?
- Does documentation indicate that program participant agrees to receive mail before documents mailed to program participant?
- Was transitioning of program participant to a different CM or form of Case Management discussed with program participant, if applicable?

QUESTIONS

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Thank you for your participation.

This concludes Module 4 of the Illinois Ryan White Case Management Training.

Thank you for your attention today. The Program looks forward to your regional webinar where we will listen and address any comments or questions that emerged from Module 4.

Module 5: ***Case Management Activities: Post-Intake*** is the next training in the Case Management series.

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