ASSESSMENT OF THIRD PARTY INSURANCE POLICIES AND PRACTICES AMONG TITLE I, RYAN WHITE CARE ACT SUBGRANTEES IN THE GREATER BALTIMORE METROPOLITAN AREA

FINAL REPORT

SUBMITTED TO ASSOCIATED BLACK CHARITIES, INC.

June 2003

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INTRODUCTION

In authorizing the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, the US Congress expressed their intent that the cost of providing HIV care be a joint responsibility shared by service providers and Federal, State and local governments. The payer of last resort requirement was introduced in the 1990 authorization of the CARE Act and is found in Parts A, B, C, and F of the Act. Under the payer of last resort requirement, CARE Act grant funds cannot be used to make payments for any item or service if payment has been made, or can reasonably be expected to be made for an item or service under any State compensation program, an insurance policy, or Federal or State health benefits program; or by an entity that provides prepaid health care.

While the CARE Act established the payer of last resort requirement in 1990, the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) did not issue detailed guidance for over a decade regarding how CARE Act grantees and their subgrantees or contractors were to operationalize the requirement. For example, in the Title I Fiscal Year (FY) 2003 Grant Application Guidance issued on July 12, 2002, Title I grantees were:

> "*…encouraged to make effective use of strategies to coordinate between Title I and third party payers who are ultimately responsible to pay the costs of services provided to eligible or covered persons. Third party payer sources include Medicaid, State Children's Insurance Programs (SCHIP), Medicare and private insurance. Grantees and their subcontractors who provide Medicaid-covered services must be Medicaid certified. CARE Act funded services may not be used to pay for Medicaid covered services for Medicaid beneficiaries*."[1]

In the absence of articulated guidance, CARE Act grantees and subgrantees throughout the US implemented a variety of approaches to address the payer of last resort requirement. Resources were not specifically made available by HAB to grantees or subgrantees to assist them to establish billing systems, train personnel in eligibility determination, or identify services covered by Medicaid or other third party insurers. The principle strategy used by grantees to implement the payer of last resort requirement was to require that subgrantees seek third party reimbursement from public and commercial insurers. Since covered services and populations vary significantly from state to state and among insurers, it was commonly difficult to determine if subgrantees were implementing the CARE Act payer of last resort requirement as intended by Congress.

In response to questions posed to HAB staff and their technical assistance (TA) contractors, HAB issued a set of questions and answers on December 6, 2002 that clarifies HAB's payer of last resort policy and outlines how that policy should be operationalized. A copy of that guidance is attached to this report and can also be found at: http://www.hrsa.gov/tpr/tech-assistance.htm.

In addition to the December 6, 2002 guidance, HRSA is also supporting training and TA for grantees and subgrantees regarding how to operationalize the payer of last resort requirement and

[1] HIV/AIDS Bureau, Title I FY 2003 Grant Application Guidance. Rockville: Health Resources and Services Administration, July 12, 2002, p. 33. http://www.hab.hrsa.gov/grants/grant91.htm.

increase third party reimbursement. This report summarizes an assessment of third party reimbursement policies and practices among a group of nine Title I-funded agencies located in the Greater Baltimore Title I Eligible Metropolitan Area (EMA). The report also outlines the TA provided to the agencies.

PROJECT OBJECTIVES AND ACTIVITIES

Associated Black Charities, Inc. (ABC) contracted in November 2002 with Positive Outcomes, Inc. (POI) to assist in determining the Greater Baltimore EMA's ability to assess third party reimbursement capacity of Title I-funded subgrantees or providers.

POI is an independent consulting firm in Maryland engaged in public health care program, financing, policy, and service system development, cost and clinical outcomes research, and program evaluation. POI focuses principally on HIV and other infectious disease-related projects. POI has conducted numerous HAB-funded on-site assessments, provided TA, and conducted workshops throughout the US for CARE Act grantees and subgrantees regarding third party reimbursement and related finance issues. Additionally, POI staff has assisted HRSA in the development of the December 2002 guidance regarding the payer of last resort requirement. Moreover, the POI Chief Executive Officer, Dr. Julia Hidalgo, has worked in HIV financing and delivery in Maryland for many years and is very familiar with the subgrantees participating in the assessment.

POI was charged with preparation of a report with recommendations regarding structural and financial barriers that impede third party reimbursement. The objectives of the project undertaken by POI were to:

1. Refine a POI third party reimbursement assessment instrument to reflect Maryland-specific funding streams.[2]

2. Undertake site visits at nine Title I subgrantees identified by ABC staff.

3. Prepare confidential subgrantee site visit reports that summarize findings of the site visit, TA provided during the site visit, and recommendations regarding activities to address third party reimbursement, payer of last resort, and related issues. Subgrantees participating in the assessment were assured by ABC that the site visit reports were confidential so that proprietary information could be discussed during the site visit, personnel performance could be reviewed, and internal institutional impediments to third party reimbursement and payer of last resort policies requirements could be discussed.

4. Identify and report to ABC staff about major structural barriers or policies that impede subgrantees from undertaking their Title I contractual requirements, including barriers or policies of ABC in their role as the administrator of Title I funds in the Greater Baltimore EMA.

5. Summarize the results of the site visits in a report to ABC that presents an overview of the

[2] A copy of the third party assessment instrument can be found on the POI website at: www.positiveoutcomes.net.

results of the assessments, TA provided during the site visits, further TA needs and sources of assistance, and recommendations regarding ways to reduce structural and financing barriers that impede third party reimbursement.

METHODS USED TO CONDUCT THE ASSESSMENT

The third party assessment methods used by POI in previous projects were reviewed and revised to reflect the unique HIV financing system in Maryland and the Title I requirements of ABC. To update the POI third party assessment instrument, POI staff interviewed ABC staff and reviewed Maryland Medicaid eligibility, covered services, and program requirements available on the Maryland Department of Health and Mental Hygiene (DHMH) website.

Subgrantees were identified by the ABC project officer as being willing to participate in the assessment. The subgrantees were selected based on their previous requests for TA regarding third party reimbursement and payer of last resort issues. Due to the selection criteria used by ABC, the results of this assessment are specifically related to the sites visited and are not necessarily generalizable to other Title I subgrantees in the Greater Baltimore EMA.

The participating subgrantees received an introductory letter and a copy of the site visit instrument from POI. Introductory materials from POI assured that the results of their site visits would be kept confidential by POI staff and that any summary reports would not identify the comments of individuals or the policies or practices of individual HIV programs. As a result of this condition of participation and the small number of subgrantees participating in the assessment, POI does not include information in this report that might be used to identify individuals or programs.

The subgrantees agreeing to participate in the assessment were asked to provide POI with up-to-date background information regarding their programs, including fiscal data where available. As shown in Table 1, nine Title I subgrantees participated in an assessment that was conducted by Dr. Hidalgo between December 2002 and February 2003. During the site visits, POI staff used the POI third party assessment instrument to guide discussions with HIV program managers, clinicians, case managers, reception and registrar staff, and billing and accounting staff.

Table 1. Title I-Funded Agencies Participating in the Third Party Reimbursement Assessment

1. Anne Arundel County Health Department
2. Baltimore County Health Department
3. Harford County Health Department
4. Howard County Health Department
5. Park West Medical Center, Inc.
6. Sisters Together and Reaching (STAR)
7. University of Maryland Institute of Human Virology Evelyn Jordan Center
8. University of Maryland Pediatric AIDS Program
9. University of Maryland Baltimore School of Dentistry

Following the site visits, site visit reports were completed by POI and submitted to the subgrantees for their review and comment. Modifications to the site visit reports were made at the request of the subgrantee's staff.

SUMMARY OF FINDINGS

Third Party Reimbursement and Payer of Last Resort Issues

- The subgrantees varied in their ability to conduct eligibility determination for discretionary and entitlement programs such as the CARE Act, Medicaid, and Medicare. The subgrantees tend to focus their eligibility determination efforts on the initial client intake rather than periodic re-determinations as the client's clinical and economic status changes.

- The ability of the subgrantees to bill third party payers is significantly constrained by the high rate of uninsured clients in their programs. These clients are reported to be uninsured because they work in industries that commonly do not provide health insurance benefits to their employers, are ineligible for publicly funded insurance because they are unemployed and not disabled, they are not eligible for Temporary Assistance to Needy Families, or their claim for coverage in a disability-based insurance program has been denied.

- Subgrantees also report that underinsurance is a common problem among HIV-infected persons, such as clients who are not insured for dental care or who have very limited dental coverage.

- Subgrantees report that in the past, Title II-funded Supplemental Security Income (SSI) enrollment assistance has resulted in significantly reduced waiting times between application and enrollment. They also report that there was a relatively low rate of rejected applications. Since the Maryland Title II Program eliminated funding for that service, case managers have directly referred their clients to the Baltimore City and County Department of Social Services and the regional Social Security Administration (SSA) office for eligibility assistance. Subgrantees report that some of their case managers do not have the expertise to assist their clients to complete the documentation required for enrollment. Subgrantees report that the rate of rejected SSI claims is growing.

- Several of the subgrantees report that their case managers have encountered growing impediments in enrolling their clients in the Maryland AIDS Drug Assistance Program (MADAP), including the Temporary Assistance Program (TAP). The subgrantees report that policies regarding eligibility determination and documentation appear to be inconsistently applied, enrollment forms are not readily available, application processes are burdensome for clients and case managers, and the time taken to complete determinations by MADAP staff is growing. These challenges have resulted in delayed or denied enrollment in MADAP.

- Several of the subgrantees were unaware that they were providing services that may be covered by public and commercial insurers. These services include blood draws for laboratory tests, HIV pre-and post-test counseling, non-emergency medical transportation, and some medical procedures. These billable procedures were identified during the site visits.

Additionally, several subgrantees were not aware that they might be eligible to participate as an HIV targeted case management providers through the HealthChoice Program.

- Most of the subgrantees report that they their staff is engaged in unfunded primary and secondary prevention education and related services.

- All but one of the nine subgrantees participates as a Medicaid provider. The subgrantee offers case management services provided by personnel that do not currently meet Medicaid provider credentialing requirements.

- Subgrantees report that some of their staff is not appropriately credentialed to be a covered provider for some insurers. For example, several subgrantees employ non-licensed personnel to provide mental health counseling or HIV targeted case management.

- All but one of the nine subgrantees have billing systems in place to process fee-for-service insurance claims. The institutions in which the subgrantees operate maintain their systems. As a result, institution-based policies and procedures are in place at the sites visited. All the billing systems reviewed appear to address third party coverage, claims generation and submission, and rejected claims resubmission. It should be noted, however, that several subgrantees were unable to generate third party revenue for their insured clients. Several of the accounting systems reviewed cannot separately account for revenue generated by the subgrantee through third party billing. Several subgrantees report that they do not bill for their services because there are a small number of insured clients, insurers do not cover most of the services provided by the program, and there are insufficient resources to support the cost of claims processing. The administrative funds provided under their Title I contract were reported to be insufficient to support claims processing at that site.

- All of the subgrantees participating in the Maryland Medicaid Program report that their staff routinely checks the electronic verification system to determine if a client has enrolled in Medicaid. If a client has enrolled in Medicaid, the subgrantees' billing staff retrospectively bill for services rendered during the enrollment period.

- The training of billing staff regarding the application of Common Procedure Terminology (CPT) coding was found to vary significantly among the subgrantees. For example, several subgrantees reported that their billing staff could benefit from additional training in the assignment of CPT evaluation and management (E and M) codes.

- Subgrantees report that public and commercial insurers do not cover many of the psychosocial services provided to HIV-infected clients. For example, commercial insurers, the Veterans Administration, and Medicaid do not cover community-based HIV targeted case management. Some routine HIV clinical services, such as HIV treatment education and adherence counseling, are also not covered by most payers. These services now represent a considerable portion of the medical visit for many of the clients served by the clinical subgrantees.

- Four of the nine subgrantees routinely bill for medical and related health care services. They report that the fee-for-service payments made by both public and commercial insurers do not

cover the cost of complex and lengthy visits commonly required to treat HIV-infected medical and dental patients. The extent of uncompensated services is unclear as some of the accounting systems maintained by the institutions in which subgrantees are located do not routinely track their uncompensated care costs specifically for HIV-infected patients.

- Several subgrantees do not have a Medicaid HIV targeted case management provider number. Staff of several subgrantees report that it is unclear if the State is awarding new case management provider numbers, particularly given the implementation of the HealthChoice Program. Some of the subgrantees do have Medicaid HIV targeted case management provider numbers. Among that group, however, only one agency has a contract with a HealthChoice managed care organization (MCO). As a result, most of the agencies participating in the assessment cannot bill for case management services provided to Medicaid beneficiaries.

- Subgrantees report several impediments to contracting with HealthChoice MCOs. Clinical programs state that they have not been able to interest the MCOs in contracting with them through either fee for service arrangements or the enhanced HIV/AIDS capitation system. Several County Health Departments report that their agencies do not have contracts with HealthChoice MCOs so it would be difficult to convince the leadership of their Departments to pursue a contract only for HIV-infected clients. Other subgrantees have attempted to negotiate case management contracts but have found that HealthChoice MCOs prefer to directly provide case management. One subgrantee reports that they had a contract with an MCO for HIV case management, however, they were never referred any clients.

- The staff of most of the subgrantees stated that Medicaid beneficiaries are not receiving needed services from their case managers employed by HealthChoice MCOs. The subgrantee staff reports that HealthChoice case managers tend to address immediate medical care coordination issues and then ”close the case.” They apparently are not trained in the basics of HIV care management, are uncomfortable with handling housing or other psychosocial issues, and are unfamiliar with local resources. Long-term case management care plans are not established and implemented by the HealthChoice case managers. Continuity of case management is a problem when HIV-infected members disenroll and join another MCO. Subgrantees report that HealthChoice case managers commonly refer complex patients with multiple psychosocial needs to Title I-funded HIV case managers for information, referral, and follow-up. HIV-infected Medicaid beneficiaries also commonly self-refer to Title I-funded case managers. Several case managers report that they feel ethically bound to assist the Medicaid beneficiaries due to the crisis nature of their problems.

- The CARE Act requires that a sliding fee scale be in place and used to determine out-of-pocket payments for covered services.[3] A sliding fee scale is not being used in most of the subgrantees participating in the assessment. Although most subgrantees report that their institution had a sliding fee scale in place, clients are not being evaluated to determine if they should pay an out-of-pocket payment. The subgrantees that do not use a sliding fee scale report that there are not mechanisms in place to collect, secure, account for, and deposit cash

[3] The sliding fee scale requirement is cited in Section 2605(e) of the Ryan White CARE Act and is referenced in the FY 2003 Title I Agreements And Compliance Assurances**.**

in their facilities. Additionally, several subgrantees report that if patients made out-of-pocket payments, the funds would be returned to their institution's general fund and not credited to the subgrantee's budget. The challenges experienced regarding collection of out-of-pocket co-payments are also reported to impede insurance co-payments.

- Most of the clinical subgrantees report that their institutions' collection departments work with self-pay patients to develop a payment plan. If a patient does not meet their payment agreement on a timely basis, they are referred to collections.

- Most of the subgrantees have made significant efforts to diversify the sources of funding used to support HIV care. Commonly, the subgrantees received Title I and II funds, other federal grant funds, County and State HIV funds, as well as health insurance payments. Several subgrantees, however, were unaware that they may be eligible for CDC funds for HIV counseling and testing.

- Several of the subgrantees are located in County Health Departments that allocate significant levels of County funds to support HIV care. It is unclear if the level of support currently underwriting the infrastructure of County HIV programs may decrease in the months to come. Several County government budgets are reportedly being trimmed due to loss of tax and other revenue, reduced State contributions to County funds, and increased costs related to public safety and education.

Contractor Care Management And Staffing Issues

- Broken appointment rates vary considerably among the subgrantees. The subgrantees report that they have used a variety of methods to reduce broken appointment rates. Some approaches, such as offering free transportation, have resulted in reduction of broken appointments rates among some subgrantees. Other subgrantees continue to have relatively high broken appointment rates.

- Several County Health Departments report that personnel policies preclude the hiring of full-time employees. As part-time employees do not have the same benefits as full-time employees, such restrictions are likely to impact employee retention and future expansion of services. Additionally, these subgrantees cannot hire new staff if a documented source of support, such as an award letter, has not been received. This policy tends to delay the start of new services and results in unexpended funds early in the Title I contract period.

Collaboration With Other HIV Providers

- Several of the subgrantees host co-located services with other agencies. These co-located, one-stop programs provide accessible HIV services throughout the EMA. However, no rent or other costs are paid by the co-located agencies. Additionally, host agency staff provides significant levels of clinical and administrative support, including appointment scheduling and medical records management that are not compensated by their co-located partner agencies.

Identifying Other Community Resources

- Subgrantees report that they have established referral linkages with other community resources to ensure that CARE Act funds are the payer of last resort. It was noted by subgrantee staff, however, that some of these services are available on a limited basis or are geographically inaccessible. Transportation must be arranged to ensure that clients can obtain services outside their county. Transportation by cab is reported by the subgrantees to be expensive.

Other HIV Service Planning and Delivery Issues

- Long-range planning and services development by the subgrantee are hampered since agencies must reapply annually for Title I funds in rolling three-year cycles. Annual application requirements result in a significant administrative burden that is not covered in the Title I administrative cap. Additionally, subgrantees report that they do not have the flexibility to apply for additional Title I service categories for three years until new applicants are accepted.

- All of the subgrantees report that the administrative funds provided by Title I are inadequate to support the administrative functions required to meet Title I contractual requirements. County or institutional funds must supplement Title I administrative funds to ensure that the subgrantees are in compliance with contract requirements.

- All of the subgrantees report that the Title I and Title II application and reporting processes result in a significant administrative burden that is not covered by the Title I administrative cap. Separate applications for each Title I service category must be prepared. Changes in the last round of Title I funding applications resulted in significant alterations in the format of the applications. More staff time was required than in previous years to prepare the applications.

- Several subgrantees identified problems in the distribution of direct financial vouchers by their HIV case managers. Title I policies prohibit the use of retrospective back payment of outstanding utility or rent bills. Clients may not identify a problem in communication with their HIV case manager until they receive a shut-off or eviction notice. Vouchers cannot be used to pay previous bills, only the current month's bill. Without payment for accumulated bills, the utility or housing management will continue to pursue suspension of service.

- Several of the subgrantees participating in the assessment stated that Title I outcomes reporting requirements are difficult to meet because their staff is not directly involved in the provision of clinical services. This information is not easily obtained from their clients' clinical providers. Barriers to retrieval of clinical information are likely to significantly increase with the April 2003 implementation of the medical records privacy sections of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Each of the subgrantees stated that there needs to be considerable improvement in the coordination of the Title I and Title II programs. For example, eligibility criteria and standards of care are different. Title I and Title II program staff do not appear to routinely

communicate and coordinate their activities. Subgrantees report that the Title I and II programs sometime work at cross-purposes, resulting in confusing and conflicting policies and procedures. For example, the performance measures, report formats, and deadlines are different and require separate data systems or paper records.

TECHNICAL ASSISTANCE PROVIDED DURING THE SITE VISITS

As shown in Table 2, Dr. Hidalgo provided on-site TA on an array of topics to the staff of the nine subgrantees:

Table 2. TA Topics Covered During Site Visits by POI to Nine Title I Subgrantees in the Greater Baltimore EMA

Implementation of the HAB third party reimbursement policy	Diversification of funding for community-based organizations and development strategies
Implementation of the HAB payer of last resort policy	Accessing CDC prevention and counseling and testing funds
Implementation of the HAB sliding fee scale policy and policies and procedures for collection of out-of-pocket payments and insurance co-payments	Accessing Title III funds for HIV clinical programs
Methods for becoming a Medicaid provider and services covered by Medicaid	Marketing of services to clients, other providers, insurers, and MCOs
Policies and procedures regarding eligibility determination and methods to obtain out-stationed Medicaid eligibility determination workers	Resources for quality assessment and improvement
Approaches to marketing to HealthChoice MCOs and negotiating contracts	Policies and procedures to increase kept medical and other client appointments
Training and credentialing to prepare subgrantee personnel to become insured providers	Sources of information regarding case management models used by CBOs
Application of Title I administrative cap funds to cover facility fees	HIPAA compliance

Additional training needs that could not be addressed in the scope of the site visits are shown in Table 3. Funds to support these TA and training needs might be sought via the HAB Title I Project Officer. Alternatively, Title I subgrantees may make a direct request for TA and training from: the National Minority AIDS Coalition (NMAC), the CAEAR Foundation's Supporting Networks of HIV Care Program, or the John Snow, Inc. (JSI) HRSA Managed Care Technical Assistance Program.

Table 3. Training and Technical Assistance Topics Identified by POI as Required by Title I Subgrantees in the Greater Baltimore EMA
TRAINING
Implementation of the HAB payer of last resort policies regarding third party billing, sliding fee scale, and collection of out-of-pocket payments and insurance co-payments
Approaches to marketing to HealthChoice MCOs and negotiating contracts
Clinical evaluation and management (E & M) coding
HIPAA requirements
Technical Assistance
Review of submitted third party insurance claims to identify uncharged or inadequately charged procedures or rejected claims that require research, correction, and resubmission

RECOMMENDATIONS

Third Party Revenue and Payer of Last Resort Issues

- HIV-infected individuals residing in the Greater Baltimore EMA may be eligible for an array of entitlement and discretionary programs. Identifying the appropriate programs for which clients can enroll is a daunting task; one that often requires provision of assistance to clients in preparing enrollment applications and advocating on behalf of the client. Further assistance is often needed to counsel clients if their initial claims for enrollment are rejected. Substantial improvement in the frequency and nature of eligibility determination is needed by many of the subgrantees participating in the site visits. Although case managers in the Baltimore EMA commonly undertake this role, they may not be the most cost effective personnel to achieve thorough and periodic determinations. The Title I and II grantees might collaborate to develop an alternative approach to eligibility determination and client advocacy. For example, an agency might be funded to provide decentralized eligibility determination and legal services at out-posted sites throughout the EMA. Paralegals and other personnel with expertise in eligibility determination or coordination of benefits might be employed to undertake these tasks. Employees hired to conduct eligibility determination would receive intensive training initially and frequent retraining as changes are made to the enrollment criteria for major entitlement and discretionary programs. Benefits counseling might also be provided to HIV-infected residents of the EMA to assist clients to prudently shop for health insurance. Staff of the program might review marketing materials to ensure that common HIV clinical services are adequately covered by insurers' benefit packages and that experienced HIV providers are included in MCO provider networks. Eligibility determination workers could work closely with case managers to coordinate benefits and ensure that changes in client clinical or economic status are rapidly identified so that eligibility can be re-determined. This approach emphasizes the importance of shifting clients from CARE Act funded services to other programs to which they are legally entitled. Moreover, this approach would result for many clients in income support and access to health care that is broader than that covered by the CARE Act. Since this approach is unique among HIV systems of care, demonstration funds might be sought from HAB, the Centers for Medicaid and Medicaid Services (CMS), SSA, or foundations.

- A resumption of SSI eligibility assistance would aid clients to rapidly enroll in Medicaid and receive disability income. Rapid enrollment of clients in the SSI Program would also reduce the number of clients that require services through Title I, Title II, or MADAP. The Title I and Title II programs might collaborate to resume funding of the program. Outreach should be initiated with SSA staff to reestablish mechanisms for rapid processing and determination of SSI applications.

- The Maryland Title II Program should undertake a review of MADAP eligibility determination and enrollment policies and staff practices to identify impediments to the rapid determination and enrollment of clients in MADAP.

- ABC staff should facilitate a workshop to be convened by the Maryland Medicaid Program staff for Title I, II, III, and IV grantees and subgrantees to review: procedures for becoming a Medicaid fee-for-service provider, provider credentialing requirements, mechanisms for participating as an MCO case management provider and/or HIV targeted case management program, services and procedures covered by the fee-for-service and HealthChoice programs, provider grievance procedures, and related billing issues. Such a workshop might be convened annually to provide up-to-date information, orient newly hired personnel, and train the staff of newly funded grantees and subgrantees.

- Title I subgrantees should receive written guidance from ABC regarding HAB's payer of last resort, billing, sliding fee scale, out-of-pocket payment collections, and revenue retrieval requirements.[4] The December 2002 guidance from HAB should be distributed to all subgrantees. A workshop might be convened for all Title I subgrantees to review these policies and assist subgrantees to develop practical approaches to adhering to the policies. Additionally, ABC might propose to HAB a waiver process by which subgrantees with special circumstances could petition for exemption of these requirements. That waiver process could be coordinated with the HAB Title I project officer so that the Title I grantee and ABC are assured that they are complying with HAB's policies.

- A workshop on medical records and billing coding might be convened under the auspices of the HRSA Center for Health Services Financing and Managed Care's Third Party Reimbursement Training and Technical Assistance Program for HRSA Grantees and Subgrantees. Although such a workshop is scheduled in Baltimore for April 2004, the workshop is fairly general and does not focus on coding of HIV-related procedural coding. Additional information about the Training and TA Program can be obtained at: http://www.hrsa.gov/tpr/.

- Staff of ABC and Maryland Title II Program might collaborate to expand funding for HIV treatment education and adherence counseling. For example, discussions might be initiated with the Maryland Medicaid Program regarding coverage of these services under the Medicaid State Plan. Additional Title I and II funds might be allocated to support these activities.

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[4] HAB requires that third party and other revenue generated by an HIV program funded by the CARE Act be credited to the HIV program's account and not retained by the institution in which the HIV program is operated.

- Staff of ABC should facilitate a meeting between Title I clinical subgrantees and DHMH HIV counseling and testing program staff to discuss State and federal funding mechanisms available to support the HIV counseling and testing activities of the subgrantees. Similarly, a meeting should be convened between Title I subgrantees engaged in HIV primary and secondary prevention activities and DHMH HIV prevention services staff to discuss ways to fund those services.

- The HealthChoice HIV/AIDS capitation system should be independently evaluated to assess the quality of HIV clinical and case management services provided by HealthChoice MCO networks. Additionally, the evaluation should assess the extent to which HIV-experienced clinical and case management providers are able to participate in the system. Barriers to participation should be identified and eliminated.

- Subgrantees report that they must provide case management services to the HIV-infected beneficiaries of HealthChoice plans to compensate for the inability or unwillingness of the plans to provide case management. As discussed above, ABC staff should request that the Maryland Medicaid Program review the HIV targeted case management services provided by HealthChoice plans. Such a review should determine if the plans are meeting the requirements of their contracts and if Medicaid beneficiaries are receiving the case management services outlined in the Maryland State Medicaid Plan. If it is unclear whether the HealthChoice plans are meeting their contractual requirements, a formal evaluation should be conducted. Additionally, ABC should collaborate with the Medical Assistance Program and AIDS Administration to establish an ongoing HIV case management taskforce to promote communication and collaboration between the HealthChoice case management staff and community-based HIV case management programs.

- If the recommended efforts to ensure that HealthChoice plans provide quality targeted HIV case management do not result in corrective action, the Planning Council should reconsider their policy regarding paying for case management to Medicaid beneficiaries. Title I and Title II staff should consult with HAB to develop an approach to funding case management services that complies with HAB payer of last resort policies.

- While it is important that structural barriers preventing generation and retention of third party revenue by subgrantees are eliminated, it is unlikely that insurance payments will provide a significant amount of revenue. The amount of revenue is likely to be low because of the low number of insured clients, the types of procedures offered by HIV program staff, and the payment levels associated with these procedures. These considerations must be weighed, however, with HAB's third party billing and payer of last resort requirements.

Other HIV Service Planning and Delivery Issues

- While multi-agency co-located services has resulted in significantly expanded geographically accessible services throughout the EMA, host agencies are not compensated for the administrative expenses resulting from co-location. Host agencies might request that the organizations that they co-locate with use a portion of their administrative cap to support the administrative costs of the host agency. Title I funds should also be considered for direct services provided by host agencies as part of their co-located activities.

- Treatment education and adherence services are an important aspect of HIV case management services provided by subgrantees. Title I or Title II funds might be allocated in the future to support these activities. The Maryland Medicaid Program might also be asked to consider coverage of these services, as the services are likely to be highly cost effective.

- The Title I administrative cap funds are reported by all subgrantees as being inadequate to meet the contract requirements. Since the 10% administrative cap is set in the CARE Act, grantee staff should determine ways in which administrative, programmatic, and reporting burden can be reduced. Any new administrative, programmatic, or reporting requirements should be assessed prior to implementation to determine if existing requirements can be eliminated or reduced.

- Title I procurement policies and procedures are reported by the subgrantees to create significant barriers to Title I funding, as well as generate uncompensated administrative costs. An independent review of the procurement process might be considered to identify ways to reduce administrative burden and cost. For example, copying costs could be reduced or eliminated by accepting electronic applications. Title I contractors should be invited to provide comments to the reviewers so that their concerns can be reflected in the findings of the review. The Title I Planning Council and ABC should use the findings of the review to undertake changes in policies and procedures.

- ABC should request TA from HAB regarding the effective use of emergency financial vouchers to address outstanding balances accumulated over time for utility and rental bills.

- All the subgrantees participating in the assessment stated that Title I monthly reporting requirements have created significant uncompensated administrative costs and diverts staff from client services. It is recommended that quarterly reporting be implemented.

- Ad hoc data represent administrative burden that is reported by contractors to divert their attention from service to clients. Ad hoc data requests should be kept to a minimum. Subgrantees should be provided with sufficient time to collect the data and provided with reports summarizing the data collected.

- In developing mechanisms to collect outcomes data, the Title I and Title II program staff should identify mechanisms to facilitate collection of outcomes data for clients served by multiple agencies.

- All subgrantees reported that improved communication and collaboration is needed between the Title I and Title II programs regarding funding, planning, and provision of HIV services. It is recommended that discussions be initiated between Title I and Title II grants management staff to establish improved communication and processes for collaboration. An independent facilitator might be engaged to assist Title I and Title II staff to overcome barriers to positive communication and collaboration. Joint needs assessment and reporting processes should be initiated after establishment of improved communication.