

Ryan White Program Service Delivery Guidelines Fiscal Year 2016 (Year 26)



*Miami-Dade County
Office of Management and Budget
Grants Coordination*

Effective March 1, 2016

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RYAN WHITE PROGRAM SERVICE DELIVERY GUIDELINES
FY 2016 (YEAR 26)

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**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2016
(Year 26)**

**Section I –
Service Definitions**



*Miami-Dade County
Office of Management and Budget
Grants Coordination*

I. GENERAL REQUIREMENTS – All Service Categories

[IMPORTANT NOTE: Except for residential substance abuse treatment services, all Ryan White Program Part A and Minority AIDS Initiative-funded services are restricted to outpatient services only.]

A. Service Delivery Standards: All providers will adhere to the *Ryan White Program System-wide Standards of Care* and other applicable standards and guidelines that are relevant to individual service categories (i.e., *Ryan White Program Medical Case Management Standards of Service*, Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease, HAB HIV Performance Measures, etc.), as may be amended. Please refer to Section III of this book for details.

B. Client Eligibility Criteria: Providers must document that clients who receive Ryan White Program-funded services have a Ryan White Program Certified Referral or have documentation on file that the client:

- Is HIV positive or has AIDS; a confirmatory HIV test result is required, unless otherwise specifically noted herein;
 - NOTE: For the purpose of linkage to care for a newly diagnosed client who has a preliminary reactive test result and a pending confirmatory HIV test result only, such clients may receive limited medical case management, outpatient medical care, or outreach services while the confirmatory HIV test result is pending. These limitations are further detailed under the corresponding service definitions in Section I of this local FY 2016 Ryan White Program Service Delivery Guidelines book. This is necessary in order to reduce a related barrier in accessing care in a timely manner for this population. Services funded by Ryan White Program dollars will either continue or cease for the client depending on the results from the confirmatory HIV test.
- Has a documented gross household income that does not exceed 400% of the 2016 Federal Poverty Level (FPL) for core medical services (see below for definition);
 - Income level caps for support services vary and can be found in the individual service definitions located in this book.
 - Although the Ryan White Program has no cash asset qualifications, providers are required to check for Property Information on the property tax page of the Miami-Dade County Tax Collector website (<https://www.miamidade.com/taxes.com/public>) to ensure that all Ryan White Program-eligible clients are screened at initial intake and at each 6-month re-assessment to ensure that they do not have additional income from rental property. Clients who have more than one property listed in

their name must have their gross household income adjusted accordingly. Documentation to support the completion of this search (showing additional properties or no properties) must be filed in the client's chart.

- Is a current and permanent physical resident of Miami-Dade County;
- Is documented as having been properly screened for Medicaid, Medically Needy (Share of Cost), Medicaid Project AIDS Care (PAC) Waiver, Medicare, other public sector funding, and private insurance, as appropriate. While clients qualify for and can access Medicaid, Medicaid PAC Waiver, Medicare, other public funding, or private insurance for services, they will not be eligible for Ryan White Program-funded services, except for those services, tests, and/or procedures, etc., related to the client's HIV disease that are not covered by other funding sources.
- The Ryan White Program is the payer of last resort; with the exception of clients who have Veterans Administration (VA) benefits, are otherwise eligible for Ryan White Program services, and choose to access the Ryan White Program first.

PLEASE NOTE: Some service categories (i.e., legal assistance, transportation services, etc.) may have more restrictive client eligibility criteria. Carefully review each service category description for additional information.

Additionally, Ryan White Program clients must be re-assessed for income and Miami-Dade County residency eligibility every six (6) months as mandated in the *Ryan White Program Medical Case Management Standards of Service*, unless otherwise specified.

CLIENT ELIGIBILITY DOCUMENTATION, INCLUDING SPECIFIC DOCUMENTATION REQUIRED FOR THE SERVICE CATEGORY (E.G., PHYSICIAN'S CERTIFICATION OF HOMEBOUND STATUS, LETTER OF MEDICAL NECESSITY, ETC.), MUST BE MAINTAINED IN EACH ORGANIZATION'S CLIENT CHARTS AND IS SUBJECT TO AUDIT BY THE OFFICE OF MANAGEMENT AND BUDGET-GRANTS COORDINATION (OMB-GC). FAILURE TO MAINTAIN CLIENT ELIGIBILITY DOCUMENTATION MAY RESULT IN FORFEITURE OF REIMBURSEMENT FOR SERVICES RENDERED.

- C. Core Medical Services:** These services, as defined in the Ryan White HIV/AIDS Treatment Extension Act of 2009, include outpatient medical care; prescription drugs; oral health care; health insurance premium and cost-sharing assistance for low-income individuals; medical nutrition therapy; mental health services, substance abuse outpatient care; and medical case management, including treatment adherence services. Ryan White Program clients may access any of these services without restriction as long as Ryan White Program eligibility has been determined either via a Ryan White Program Certified Referral or an Out-of-Network (OON) referral, also known as the "General Certified Referral

for Ryan White Program Services,” that is generated by a non-Ryan White Program case manager. An OON referral must be accompanied by appropriate Ryan White Program supporting documentation of client eligibility for services and this documentation must be kept in the client chart at the Ryan White Program referral site.

- D. Support Services:** These services, as defined in the Ryan White HIV/AIDS Treatment Extension Act of 2009, include outreach; medical transportation; legal services; food and meal programs; psychosocial support; and residential substance abuse treatment/counseling. Except in certain outreach scenarios (see revised Outreach Services definition), clients may only receive these support services if they have a Ryan White Program Certified Referral or an OON referral for the service. The Health Resources Services Administration (our federal funder) expects that clients receiving a support service are documented as being engaged in on-going medical care and treatment.
- E. Performance Improvement and Outcome Measures:** All providers will develop internal performance improvement programs and collaborate with the Miami-Dade County Ryan White Program Quality Management Program contracted to Behavioral Science Research Corporation (BSR). Providers will be evaluated against the outcome measures contained in Miami-Dade County Professional Service Agreements (contracts), the Health Resources and Services Administration’s HAB HIV Performance Measures to include Core, All Ages, Adolescent/Adult, HIV-Infected Children, HIV-Exposed Children, Medical Case Management (MCM), Oral Health Care, AIDS Drug Assistance Program (ADAP), and Systems-Level measures, as may be amended; Ryan White Program Minimum Primary Medical Care Standards for Chart Review; Ryan White Program Oral Health Care Standards; and/or the Performance Improvement Plan (PIP) and its addenda; where applicable. They will be responsible for collecting and reporting on specific data to measure performance and outcomes, as detailed in the documents listed above.

Outpatient medical care, prescription drugs, medical case management, oral health care, substance abuse counseling, outreach, and mental health therapy/counseling providers must participate in external quality assurance reviews, utilizing individual standardized tools as developed by the Ryan White Program, the Performance Improvement Advisory Team (PIAT), and the Miami-Dade HIV/AIDS Partnership (Partnership). As individual standardized tools are developed by the Ryan White Program, the PIAT, and the Partnership for Ryan White Program-funded support services, providers will be required to utilize such tools and participate in related external quality assurance reviews.

- F. Reporting:** Providers must report monthly activity according to the recorded number of client visits, dates of services, type of procedures (if applicable), units of service provided, and unduplicated number of clients served. See individual

service category definitions for additional reporting requirements, where applicable.

In addition, the local Ryan White Program uses the nationally recognized HIV Care Continuum model to identify gaps or barriers affecting the program's ability to connect HIV+ people with outpatient medical care and support services and to improve client health outcomes. The HIV Care Continuum (or HIV Treatment Cascade) is a model used to identify issues and opportunities related to improving the delivery of services to people living with HIV across the entire continuum of care. This continuum has five steps: (1) HIV Diagnosis; (2) Linkage to Care; (3) Retention in Care; (4) Access to Antiretroviral Therapy; and (5) Viral Load Suppression. Timely reporting of service delivery information, documenting prescribed HIV medications, and uploading or manually entering viral load test results are necessary to track client health outcome, to identify gaps in service delivery or barriers to care, and to identify program improvements to assist clients in achieving and maintaining viral load suppression.

II. MINORITY AIDS INITIATIVE (MAI) REQUIREMENTS (as may be amended) – The following requirements will apply to the following service categories if funded with MAI resources: medical case management, outpatient medical care, outreach, prescription drugs, and residential substance abuse treatment/counseling services.

Funding available under the MAI for outpatient medical care (primary and specialty care), prescription drugs, medical case management, residential substance abuse treatment/counseling, and outreach services are currently identical to general Part A-funded services, except that MAI-funded services provide culturally sensitive services that target minority communities exclusively. However, pending further guidance from HRSA, this focus may change.

MAI funds are designated to reduce the HIV-related health disparities and improve the health outcomes for disproportionately impacted, HIV+ minority populations, such as Black/African Americans, Black Haitians, and Hispanics. **IMPORTANT NOTE:** For FY 2016, other minority groups not listed in this paragraph may receive services funded through the Ryan White Part A Program, not through MAI funded services.

The goal of MAI, like the Ryan White Part A Program, is viral load suppression. MAI funding should be used to address health disparities and health inequalities among minority communities. As instructed by HRSA, MAI funds are to be used to deliver services designed to address the unique barriers and challenges faced by hard to reach, disproportionately impacted minorities within the Eligible Metropolitan Area (EMA). MAI-funded services must be consistent with epidemiologic data and the needs of the community, and be culturally appropriate. MAI-funded services should use population-tailored, innovative approaches or interventions that differ from usual service methodologies and that specifically address the unique needs of targeted sub-groups.

The overarching goal of the MAI is to improve health outcomes by preventing transmission or slowing disease progression for disproportionately impacted communities by:

- Getting persons living with HIV disease into care at an earlier stage in their illness,
- Assuring access to treatments that are consistent with established standards of care, and
- Helping individuals and families to remain in care.

Organizations funded to provide MAI services in Miami-Dade County must also meet the following criteria:

- 1) Are located in or near to the targeted community they are intending to serve;
- 2) Have a documented history of providing services to the targeted community(ies);
- 3) Have documented linkages to the targeted populations, so that they can help close the gap in access to service for highly impacted minority communities;
- 4) Provide services in a manner that is culturally and linguistically appropriate; and
- 5) Understand the importance of cross-cultural and language appropriate communications and general health literacy issues (including cultural competency, limited English proficiency, etc.) in an integrated approach to develop the skills and abilities needed by HRSA-funded providers and staff to effectively deliver the best quality health care to the diverse populations they serve.

Providers must clearly specify the target population(s) to be served [i.e., Black/African American (including but not limited to Haitians) or Hispanic. If more than one racial/ethnic group is targeted, the percentage that each group will represent of the total number of minority clients to be served must be identified.

III. REFERRAL REQUIREMENTS – All Ryan White Program-funded providers may accept Ryan White Program Certified Referrals for service if the referral is current, signed and dated (by hand or electronically), includes the title of the referring medical case manager, and indicates the referral's end date, which may be different depending on the service category. The Ryan White Program Certified Referral verifies that all client eligibility documentation (HIV status, financial income level verification, and current permanent Miami-Dade County residency) and all required consents (Notice of Privacy Practices, SDIS Consent to Release and Exchange Information, and the Composite

Consent) have been gathered by the referring Ryan White Program-funded medical case manager and can be found in the client chart at the referring agency's location. Ryan White Program Certified Referral forms must also be kept on file in the client's chart at each site where a referral has been received. Failure of the referring agency to maintain appropriate eligibility documentation in the client chart, or of the receiving agency to maintain the actual Ryan White Program Certified Referral in the client chart, is subject to corrective action and fiscal repayment to the County.

A General or Out-of-Network (OON) referral may be generated by a non-Part A or non-MAI-funded case manager [e.g., Medicaid Project AIDS Care (PAC) Waiver, etc.]. However, all supporting eligibility documentation and consent forms required by Miami-Dade County must accompany the referral and be kept in the client chart or the electronic medical record at the referral site. For these referrals, a brief intake must be entered into the Service Delivery Information System (SDIS) so that the Part A or MAI-funded organization may generate reimbursement requests (billing) for services rendered. For the agency receiving an OON referral, failure to maintain the actual OON referral and all supporting documentation and consent forms on file in the client's chart or the electronic medical record is also subject to corrective action and fiscal repayment to the County. Under no circumstances can an agency receiving an OON referral require that the client be assigned a Part A or MAI-funded medical case manager.

Referrals must specify an end date that is detailed in each of the corresponding, specific service category definitions (e.g., food bank – referral expires after 4 months; residential substance abuse treatment/counseling – after 4 months; legal services – after 1 year; and health insurance assistance – on December 31st or the end date of the client's health plan policy year). The Outreach Referral end date is thirty (30) calendar days from the initial referral date. At least one encounter must be provided within this 30-day period. Final outreach services must be provided within ninety (90) calendar days of the initial referral date. After ninety (90) calendar days the case should be closed, unless there is a well-documented reason for keeping the outreach case open. OON referrals are good for up to six months, regardless of the service; then a re-certification is required.

Within the Ryan White Program network of service providers, it is the client's choice of which provider he or she wishes to receive services from.

IV. ADDITIONAL EXPECTATIONS FOR SERVICE PROVISION TO IMPROVE CLIENT HEALTH OUTCOMES – Ryan White Program-funded services should be provided in such a manner as to address the goals of the following national initiatives:

Healthy People 2020

Healthy People 2020 is a national initiative led by the U.S. Department of Health and Human Services (HHS) that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities,

and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages.

National HIV/AIDS Strategy (NHAS) – Updated to 2020

The updated National HIV/AIDS Strategy (NHAS) has four strategy goals: (1) reduce new HIV infections; (2) increase access to care and improve health outcomes for people living with HIV; (3) reduce HIV-related health disparities and health inequities; and (4) achieve a more coordinated national response to the HIV epidemic. The NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high risk communities and reduce stigma and discrimination against people living with HIV.

V. REQUIRED DISCLAIMER FOR HRSA-SUPPORTED PUBLICATIONS –

When issuing statements, press releases, request for proposals, bid solicitations and other HRSA-supported publications and forums describing projects or programs funded in whole or in part with HRSA funding, the following acknowledgement and disclaimer must be included on all products produced by HRSA grant funds:

“This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under [grant number] and [title] for [grant amount]. [i.e., specify grant number as H89HA00005, title as CFDA #93.914 - HIV Emergency Relief Project Grants, and total award amount as indicated in Attachment G of the contract. A total of ___% of this project was financed with nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.”

The grant number, title, and grant amount are found in each subrecipient’s Exhibit C, Attachment G, under the corresponding Professional Services Agreement for Ryan White Program Services in Miami-Dade County.

Examples of HRSA-supported publications include, but are not limited to, manuals, toolkits, resource guides, case studies, and issues briefs.

FOOD BANK
(YEAR 26 Service Priority #8)

Food Bank is a support service. The Food Bank program is a central distribution center providing groceries, including personal hygiene products when available, for indigent HIV+ clients. The food is distributed in cartons or bags of assorted products to eligible Ryan White Program clients. Food bank assistance will be provided on a temporary, as needed basis to eligible clients to help maintain their health by providing a balanced, adequate diet.

Food bank providers must offer nutritional counseling to all food bank clients through qualified staff supervised by a licensed dietitian or nutritionist.

Ryan White Program funds for food bank services may not be used for permanent water filtration systems for water entering the house, household appliances, pet foods, or other non-essential products.

A. Program Operation Requirements:

Standard Provisions

Food bank services may be provided only on an **emergency basis**. An emergency is defined as an extreme change of circumstance: loss of income (i.e., job loss or departure of person providing support), loss of housing, or release from institutional care (substance abuse treatment facility, hospital, jail, or prison) within the last two weeks. Duration of food bank service provision is to be **temporary**. Other emergencies, as defined by the client's medical case manager, must be documented in the client's chart as they arise. A severe change to the client's medical condition, as defined below under the provision for additional occurrences, may also be considered an emergency.

Medical case managers must conduct initial and on-going assessment of each client to determine if the client is eligible for food-related services under any other public and/or private funding source, including food stamps or other charity care food banks.

The provision of this service will be limited to sixteen (16) occurrences within the Ryan White Part A Fiscal Year (March 1, 2016 through February 28, 2017). One (1) occurrence is defined as all food bank services provided within one (1) calendar week. For example, a client could receive food bank services once a week every week for four (4) months, or twice per month for eight (8) months, in the grant Fiscal Year or any variation thereof, with the limit of sixteen (16) occurrences in the grant Fiscal Year.

Groceries, including personal hygiene products when available, can be picked up on a weekly or monthly basis. If groceries will be picked up on a **weekly** basis, the client will be limited to groceries valued at \$50.00 per week at each pick-up. A client accessing food bank services on a weekly basis may not pick up groceries sooner than seven (7) days from the prior pick-up day.

If the client chooses to pick up his/her groceries on a **monthly** basis, the client will be limited to \$50.00 per week multiplied by the number of times the original day of pick-up occurs in the month. A client accessing food bank services on a monthly basis may not pick up groceries in a new month prior to the same pick-up day from the previous month.

Providers must make every effort to obtain matching funds, donations, or any supplemental assistance for the program and these efforts should be documented. Providers must also be familiar with and capable of referring clients to other community, faith-based, and/or neighborhood food bank sites when the client is not in an emergency situation and/or has reached their food bank allowance limit.

Providers must be able to provide ethnic foods and foods suited to special client dietary needs.

Initial Referral and Additional Occurrences

A letter of medical necessity is NOT required for a referral to Food Bank services for the client's first sixteen (16) occurrences during the grant fiscal year; however, the circumstances justifying the referral to food bank services should be clearly documented in the client's chart and a Ryan White Part A Certified Referral should be generated by the medical case manager. A completed Out of Network Referral is also acceptable for this support service. Once the client's initial sixteen (16) occurrences are exhausted, the client may NOT receive additional food bank services during the same Ryan White Part A Fiscal Year (i.e., March 1, 2016 through February 28, 2017) without a **Ryan White Program Nutritional Assessment Letter for Food Bank Services**.

A **severe** change to the client's medical condition (i.e., new HIV-related diagnosis/symptom, wasting syndrome, protein imbalance, recent chemotherapy, recent hospitalization, etc.) may warrant additional occurrences of food bank services. When needed for the additional occurrences, the **Ryan White Program Nutritional Assessment Letter for Food Bank Services** must be completed by a licensed medical provider **OR** a registered dietitian not associated with the Part A-funded food bank provider. The client must be reassessed for the medical condition justifying additional food bank services every four (4) months. The physician or registered dietitian must specify the frequency and number of additional food bank visits (occurrences) that should be allowed for the client (maximum of sixteen additional occurrences).

Provision for Families

In addition to the maximum amount defined above for groceries available per week to eligible clients, each additional adult who is HIV+ and lives in the same household is eligible to receive \$50.00 per week in groceries subject to the same service guidelines. Each dependent (i.e., minors under 18 years of age and living in the same household as the client who is HIV+) is also eligible to receive \$20.00 per week in groceries, subject to the same service guidelines above. The HIV+ client must provide documentation to prove the dependent's age and place of residence.

- B. Rules for Reimbursement:** Providers will be reimbursed based on properly documented invoices reflecting the distribution of weekly bags of groceries, including personal hygiene products, plus a dispensing charge to be agreed upon between the provider and the Office of Management and Budget-Grants Coordination (OMB-GC). The cost of the weekly bag of groceries will not exceed \$50.00. Providers will also submit a quarterly reconciliation of actual expenditures for food costs, staffing expenses, and other line items as listed on the approved budget.
- C. Additional Rules for Reporting:** Providers must report monthly activities according to client visits (i.e., weekly occurrences). Providers must also submit to OMB-GC an assurance that Ryan White Program funds were used only for allowable purposes in accordance with the contract agreement, and that the Ryan White Program was used as the payer of last resort. Providers must also submit an assurance regarding compliance with all federal, state, and local laws regarding the provision of food bank services, including any required licensure and/or certifications.
- D. Additional Rules for Documentation:** Providers must maintain documentation of the amount and use of funds for purchase of non-food items, and make this documentation available to OMB-GC staff upon request.
- E. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation) is required for this service. Current referrals expire automatically on February 28th of each Fiscal Year (or February 29th if a leap year). Each medical case management referral must document the number of eligible dependents (i.e., minors). For additional occurrences, the client must be reassessed for the medical condition justifying additional food bank services every three (3) months. Providers must document that HIV+ clients who receive Ryan White Part A-funded food bank services have gross household incomes that do not exceed 250% of the 2016 Federal Poverty Level (FPL).

Clients receiving food bank services must be documented as having been properly screened for Food Stamps, Medicaid Project AIDS Care (PAC) Waiver, or other public sector funding as appropriate. Medical case managers must document a client's need for food services in the client's Plan of Care (POC), and indicate if the client is eligible to access food services under other available programs, with the understanding that the Ryan White Program-funded food bank services are provided on an emergency basis. If the client is eligible to receive food service benefits from another source, the medical case manager will assist the client in applying to such program(s). If the client already receives food stamp benefits at the time he/she applies for Ryan White Program-funded food bank services, the client must submit a copy of his/her Food Stamp program award/benefit letter as documentation that the award is \$100.00 or less per month in food stamp benefits. If the client applied for Food Stamp benefits and was denied, a copy of the denial letter must be filed in the client's chart and a copy should accompany the referral for food bank services.

While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Part A-funded food bank services. Similarly, while clients qualify for and can access other public funding for food services, they will not be eligible for Ryan White Part A-funded food bank services, unless the provider is able to document that the client has an emergency need, or has applied for such benefits and eligibility determination is pending (a copy of benefit application must be kept in the client's chart).

HEALTH INSURANCE SERVICES
(YEAR 26 Service Priority #4)

Health Insurance Services is a core medical service category. This service category includes the provision of financial assistance paid on behalf of eligible individuals living with HIV or AIDS to maintain continuity of health insurance or to facilitate receiving medical benefits under a health insurance policy. This service is available to assist low income, program-eligible clients with purchasing health insurance that provides comprehensive primary medical care and pharmacy benefits that include a full range of antiretroviral (ARV) medications. This service may cover premiums, co-payments, and deductibles on behalf of eligible clients, where allowable and as defined herein. In all cases, a complete financial assessment and disclosure from the client are required. No payments or reimbursements can be made directly to a client.

Health Insurance Services is divided into two (2) major categories: 1) limited assistance with private health insurance or employer-based health insurance, which is identified in program components I through III directly below; and 2) assistance with the Federal Health Insurance Exchange [i.e., Affordable Care Act (ACA) Marketplace], which is identified in program components IV through VII directly below. Federal funding under this service category may not be used to supplant existing federal, state, or local funding for health insurance premium and cost-sharing assistance.

Health insurance assistance under this service category is available to program-eligible HIV positive (HIV+) clients only. If a Family Plan is selected, the Ryan White Program will only provide assistance, where applicable, for the program-eligible HIV+ client. No HIV negative persons in a Family Plan will receive this assistance. Additionally, all costs in a Family Plan must be separated out, so that the costs specific to the HIV+ client are clearly indicated.

A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated prior to the end of the client's health insurance policy year. A copy of the client's insurance policy information including benefits, policy number, and billing ID number must be provided with the referral in order to process the request for health insurance assistance.

For Medicare Part D recipients, any client whose gross household income falls below 150% of the 2016 Federal Poverty Level (FPL) must be enrolled in the Low Income Subsidy (LIS) Program. In addition, for Medicare Part D recipients, any client whose gross household income falls between 135% and 150% of the FPL must be enrolled in ADAP for assistance with prescription drug expenses. For Medicare Part D recipients, any client whose gross household income falls above 150% of the FPL or does not qualify for the LIS and who falls into the "donut hole," must be referred to the ADAP Program.

I. – **III. EMPLOYER-BASED INSURANCE, PRIVATE HEALTH INSURANCE, or COBRA [NON-AFFORDABLE CARE ACT (ACA)]**

I. **AIDS Insurance Continuation Program/ADAP Premium Plus Insurance Program**

AICP assistance has been discontinued by the Florida Department of Health. Clients affected by this change were transitioned to an ACA Marketplace health insurance plan if they were eligible for the ACA; otherwise the clients were able to return to the ADAP uninsured program and could access Part A services where applicable.

II. **Health Insurance Deductibles**

This health insurance component is available to help maintain a client's existing private or employer-sponsored health insurance coverage by paying the annual deductible, thereby minimizing the client's reliance on the Ryan White Part A Program for related core medical services.

- A. **Program Operation Requirements:** Under no circumstances shall payment be made directly to recipients (i.e., clients) of this service. The maximum amount of assistance a client may receive annually is **\$2,500 per calendar year**. A complete financial assessment and disclosure are required.
- B. **Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per deductible per client, plus a dispensing rate*. Billing code **DED** must be used for this health insurance component, when applicable.
- C. **Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars expended *per deductible per client*. The service provider must also report the number of unduplicated clients served each month.
- D. **Additional Rules for Documentation:** Providers must maintain proof that the health insurance policy provides comprehensive primary care and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

III. **Prescription Drug Co-Payments and Co-Insurance**

This health insurance component is available to eligible clients with private or employer-sponsored health insurance who are required to pay a co-payment or co-insurance for their medications, but are financially unable to pay such expense.

- A. Program Operation Requirements:** Assistance for both prescription drug co-payments and co-insurance is restricted to those medications on the most current, local Ryan White Part A Program Prescription Drug Formulary. **Prescription drug co-payment assistance is not provided for clients with prescription drug discount cards.**
- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per prescription drug co-payment/co-insurance per client, plus a dispensing rate.* Billing code **COP** must be used for this health insurance component, when applicable.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per prescription drug co-payment/co-insurance per client.* The service provider must also report the number of unduplicated clients served each month.
- D. Additional Rules for Documentation:** Providers must maintain proof that the health insurance policy provides comprehensive primary care and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

IV. - VIII. LOCAL IMPLEMENTATION OF THE AFFORDABLE CARE ACT (FEDERAL HEALTH INSURANCE EXCHANGE)

According to the Affordable Care Act (ACA), the Federal healthcare law, individuals must have healthcare coverage that meets Minimum Essential Coverage or pay a fee (penalty) for each month they are without insurance coverage. Minimum Essential Coverage (MEC) is defined as the type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA. More information regarding the MEC's "10 essential health benefits" can be found at the following web page: <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>.

Ryan White Part A/MAI Program medical case managers will facilitate the process of identifying clients who are eligible to enroll in an ACA Marketplace health insurance plan. Once an ACA-eligible client is identified, wherever applicable and in order to ensure the Ryan White Program is the payer of last resort, the medical case manager will inform the client that they must enroll in an appropriate, cost-effective health insurance plan during the open enrollment period, or at other allowable times due to a qualifying event (see www.healthcare.gov for details). The medical case manager must also inform the client of the consequences (tax penalties) for not enrolling. The medical case manager will also explain the benefits of enrolling in a health insurance plan, and inform the client of any assistance for which they may qualify. The medical case

managers will make appropriate referrals to the contracted Ryan White Part A health insurance assistance service provider who will complete the process and make appropriate payments on behalf of ACA-eligible/enrolled clients.

Medical case managers are expected to discuss and complete all of the necessary Ryan White Part A Program paperwork with the ACA-eligible client and refer the client to a HIV-friendly ACA Navigator and/or Certified Application Counselor (CAC), who has been identified as such by the local Ryan White Part A grantee, for further instructions and assistance with enrollment. Medical case managers of ACA-eligible clients will assist their clients in clearly communicating the client's health care needs (e.g., HIV status, specialty care needs, physician preferences, prescribed medications, etc.), using the local ACA Assessment form. Once completed, this form will accompany the client on their visit to the ACA Navigator or CAC for assistance with evaluating the best health care plan options that meet their individual needs and are cost effective.

It is important to note that the Ryan White Program's Federal funding source, the Health Resources and Service Administration (HRSA), requires Ryan White Programs to "vigorously pursue" enrolling eligible clients in an ACA Marketplace health insurance plan. HRSA also requires its Ryan White Programs to inform such clients of the consequences of not enrolling in such a plan. Furthermore, HRSA requires Ryan White Programs to "vigorously pursue" reconciliation of any Advanced Premium Tax Credits in relation to any Ryan White Program financial assistance provided to maintain access to such health insurance benefits. For this reason, clients receiving this assistance are required to file Federal income tax returns, and submit copies of these returns and reconciliation reports to their medical case manager for possible repayment to the Ryan White Program. For purposes of compliance with Federal mandates related to the Affordable Care Act, "vigorously pursue" includes the following:

- Identify clients who are eligible to enroll in the ACA Marketplace; or clients who qualify for an ACA exemption;
- Inform ACA-eligible clients of the requirements to have Minimum Essential Coverage;
- Discuss the benefits of having health insurance with the ACA-eligible clients;
- Advise ACA-eligible clients of the federal tax penalties associated with not having Minimum Essential Coverage;
- Assist ACA-eligible clients with enrollment in the ACA Marketplace (i.e., connect them to an appropriate ACA Navigator or Certified Application Counselor);
- Document ACA enrollments and non-enrollments; and
- Reconcile Advanced Premium Tax Credits with any related tax refunds and assistance provided by the Ryan White Part A Program.

If a client is found to be ACA-eligible but chooses not to enroll in a health care plan, the medical case manager must document the client's reason for not enrolling, based on the client's completion of the local ACA Decline form in the client's own words. This communication with the client must be documented by the medical case manager in the individual progress notes in the client's chart and in the Service Delivery Information System (SDIS), the local Ryan White Part A Program data management information system.

Medical case managers must also inform their clients about the fees/penalties associated with the failure to enroll in an ACA Marketplace health insurance plan if eligible. Clients must also be informed that the Ryan White Part A Program is not allowed to assist the clients with paying the fees/penalties associated with not having Minimal Essential Coverage.

Clients are strongly encouraged not to enroll in an ACA Marketplace health insurance plan on their own. Clients who enroll on their own may inadvertently choose a plan that is not cost effective, does not sufficiently cover their needs, or does not meet the Ryan White Part A or the ADAP program guidelines or limitations for assistance. Furthermore, ADAP clients who enroll on their own in the ACA Marketplace will lose all access to ADAP assistance with ADAP prescription drugs, ACA premiums, and ACA drug co-payments.

The following documents provide additional guidance related to local implementation of and assistance with the ACA (See Section IX, Local Implementation of the Affordable Care Act Requirements, of this FY 2016 Ryan White Part A Program Service Delivery Guidelines book):

- ACA Assessment Tool
- ACA Acknowledgment form
- ACA Exemption Checklist
- ACA Decline form, when applicable (when a client chooses not to enroll, ONLY AFTER the benefits of obtaining health insurance and the tax penalties for not enrolling have been fully explained to the client)
- Policy on Reconciliation of Advanced Premium Tax Credits
- ACA Marketplace Resources (Application Checklist and Exemption Information)

Referrals to Ryan White Part A health insurance assistance (each component) will expire annually on the date the policy period ends, with an SDIS pop-up reminder 30-days prior. For example, referrals for calendar year health insurance plans will expire on December 31st, and a reminder would be issued through the SDIS on December 1st.

Local Ryan White Part A Program assistance for ACA Marketplace health insurance plans is limited to a maximum total out-of-pocket cost that is at or below \$5,200 per year. Very limited exceptions may be approved on a case by case basis.

NOTE: It is critical that all Ryan White Program medical case managers follow proper and consistent directions from the grantee (i.e., Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program) when screening Ryan White Part A and ADAP clients for ACA participation and share a clear and appropriate message with clients.

IV. ACA Premiums (Part A ACA Assistance)

This health insurance component is available to clients who are eligible to enroll in an ACA Marketplace health insurance plan, but are financially unable to pay their premiums. Assistance is limited to plans that are cost-effective, include comprehensive medical coverage, and provide access to antiretroviral (ARV) medications and other medications the client may need. It is also strongly recommended that such plans include the client's physician who manages their HIV care on an outpatient basis, as an In-Network provider. ACA Premium assistance is limited, as follows:

A. Program Operation Requirements:

For Ryan White Part A clients NOT on the ADAP ACA Transition List and NOT in ADAP, but with an eligible ACA Marketplace health insurance plan: the amount of ACA premium assistance from the Ryan White Part A Program is limited to \$750.00 per month per client.

B. Rules for Reimbursement: There is NO Ryan White Part A Program billing code for ADAP ACA Transition List clients whose health insurance premiums are paid for by ADAP.

However, providers of services to non-ADAP ACA Transition List clients will be reimbursed for dollars expended *per ACA premium per client, plus a dispensing rate*. Billing code **ACAP** must be used for ACA premium payments for clients assisted by Part A who are NOT on the ADAP ACA Transition List. Such payments can be made up to three (3) months in advance (i.e., quarterly) and payments are tracked (by monthly date range) in the SDIS reports (i.e., invoices/bills).

C. Additional Rules for Reporting: Monthly activity reporting for this service must be in dollars *per premium per client*. The service provider must also report the number of unduplicated clients served each month.

D. Additional Rules for Documentation: Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

V. ACA Deductibles (Part A ACA Assistance)

This health insurance component is available to help maintain a client's ACA Marketplace health insurance coverage by paying the annual deductible, thereby minimizing the client's reliance on the Ryan White Part A Program for related core medical services.

A. Program Operation Requirements: As payer of last resort, the Ryan White Part A Program may assist with ACA Marketplace health insurance deductible payments for eligible clients up to a maximum of \$2,500 per year.

B. Rules for Reimbursement: Providers will be reimbursed for dollars expended *per ACA deductible per client plus a dispensing rate*. Billing code **ACADED** must be used for Ryan White Part A clients who have an ACA Marketplace health insurance plan BUT are NOT on the ADAP ACA Transition List. Billing code **WRPDED** must be used for Ryan White Part A clients who have an ACA Marketplace health insurance plan AND ARE on the ADAP ACA Transition List.

C. Additional Rules for Reporting: Monthly activity reporting for this service must be in dollars *per ACA deductible per client*. The service provider must also report the number of unduplicated clients served each month.

D. Additional Rules for Documentation: Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

VI. ACA Prescription Drug Co-payments (Part A ACA assistance)

This health insurance component covers prescription drug co-payments for eligible clients who have an active ACA Marketplace health insurance policy, where applicable and within program limitations as detailed below. This component is NOT applicable to ADAP ACA Transition List clients.

- A. Program Operation Requirements:** The Ryan White Part A Program only covers prescription drug co-payments for these clients, for medications found on the most current, local Ryan White Part A Program Prescription Drug Formulary.
- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per ACA prescription drug co-payment per client, plus a dispensing rate*. Billing code **ACACOP** must be used to record ACA prescription drug co-payments for Ryan White Part A Program clients who have an ACA Marketplace health insurance policy BUT are NOT on the ADAP ACA Transition List.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per ACA prescription drug co-payment per client*. The service provider must also report the number of unduplicated clients served each month.
- D. Additional Rules for Documentation:** Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

VII. ACA Doctor Office Visit, Laboratory & Diagnostic Co-payments (Part A Co-payment Assistance Pilot Project)

This health insurance component covers prescription drug co-payments, doctor/medical practitioner office visit co-payments, and laboratory/diagnostic co-payments, for eligible clients for whom the Ryan White Part A Program is paying their ACA premiums. Until further notice, this assistance is time limited. This co-payment assistance pilot project is time limited, and is available for allowable medical services rendered through December 31, 2016, or as may be amended by the Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program.

ACA co-payment assistance under the local Ryan White Part A Program is limited to IN-NETWORK and OUTPATIENT MEDICAL CARE services only. Assistance is further limited to services in connection with the client's HIV status, related co-morbidity, or complication of HIV treatment.

A. Program Operation Requirements:

- Through the "Part A ACA Co-payment Assistance Pilot Project", eligible clients with an active ACA Marketplace health insurance policy may receive assistance with the following co-payments, if the services are IN-NETWORK, OUTPATIENT, AND related to the

client's HIV status, related co-morbidity, or complication of HIV treatment:

- Physician or medical practitioner co-payments
- Laboratory/Diagnostic co-payments

- **Co-payment assistance is limited to allowable services rendered in Miami-Dade County.**

B. Rules for Reimbursement: Providers will be reimbursed for dollars expended *per ACA co-payment per client, plus a dispensing rate.* Furthermore:

- Billing code **PTAOV** must be used for these ACA Co-Payment Pilot Project clients for whom Part A is paying their allowable doctor/medical practitioner office visit co-payments.
- Billing code **PTALAB** must be used for these ACA Co-Payment Pilot Project clients for whom Part A is paying their allowable laboratory and diagnostic co-payments.

C. Additional Rules for Reporting: Monthly activity reporting for this service must be in dollars *per Part A ACA Co-payment per client.* The service provider must also report the number of unduplicated clients served each month.

D. Additional Rules for Documentation: Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

VIII. For Part A/ADAP clients NOT on the ADAP ACA Transition List:

- Client stays in the ADAP uninsured program to receive prescription drugs on the Florida ADAP Formulary and continues receiving all other locally-funded Ryan White Part A Program services for which the client is eligible.
- Clients whose income and enrollment in ADAP would appear to make them eligible for the ADAP ACA Transition List, but have not been included on the ADAP ACA Transition List by Florida ADAP, have a choice of continued coverage under ADAP and the Ryan White Part A Program. However, these clients may incur a tax penalty when they file their income taxes, if they were eligible for ACA Marketplace insurance but did not enroll. Alternatively, they may choose to enroll in an ACA Marketplace health insurance plan “on

their own.” However, a client enrolling in the ACA on their own is not recommended for the reason stated directly below.

- **PLEASE NOTE: If an ADAP client who is not on the ADAP ACA Transition List enrolls in an ACA Marketplace health insurance plan, they will be dropped from ALL ADAP assistance. Any local Part A assistance thereafter is subject to program eligibility requirements and service limitations (e.g., caps on premiums, deductibles, and drug co-pays assistance, etc.).**

IX - X. ADAP ACA TRANSITION LIST CLIENTS ONLY, AS PART OF THE ADAP/PART A ACA WRAPAROUND PROJECT

IX. For Part A/ADAP clients on the ADAP ACA Transition List (i.e., ADAP clients with incomes at 100%-249% of the Federal Poverty Level who have been specifically designated as ADAP Transition List clients by Florida ADAP):

- ADAP assists with payments for premiums.
- For Plan Year 2016, ADAP has limited premium assistance for ADAP ACA Transition clients in Miami-Dade County to the following six (6) plans only:
 - FLORIDA BLUE – BlueOptions Everyday Health 1410 (Silver Plan)
 - FLORIDA BLUE – BlueSelect Everyday Health 1443 (Silver Plan)
 - FLORIDA BLUE – BlueSelect Everyday Health 1456 (Silver Plan)
 - FLORIDA BLUE – BlueSelect Everyday Health 1464 (Silver Plan)
 - MOLINA – Molina Marketplace Silver
 - UNITED HEALTHCARE – UnitedHealthcare Silver Compass 4000 (Silver Plan)
- The Ryan White Part A Program does NOT assist with premium payments for these ADAP ACA Transition List clients.

X. ADAP ACA Wraparound Co-payments

This health insurance component covers prescription drug co-payments, doctor/medical practitioner office visit co-payments, and laboratory/diagnostic co-payments, for eligible clients who were on the ADAP ACA Transition List AND have an active ACA Marketplace health insurance policy, where applicable and within program limitations as detailed below.

ACA co-payment assistance under the local Ryan White Part A Program is limited to IN-NETWORK and OUTPATIENT MEDICAL CARE services only. Assistance is further limited to services in connection with the client's HIV status, related co-morbidity, or complication of HIV treatment.

A. Program Operation Requirements:

- ADAP covers the prescription drug co-payments for all medications on the most current Florida ADAP Formulary, for eligible ADAP ACA Transition List clients with an active ACA Marketplace health insurance policy under one (1) of the four (4) ADAP-approved health insurance plans. The following web page includes a list of the most current Florida ADAP Formulary medications:
<http://www.floridahealth.gov/diseases-and-conditions/aids/adap/adap-formulary.html>
- Through the Ryan White Part A Program's "ADAP/Part A ACA Wraparound" component, eligible ADAP ACA Transition List clients with an active ACA Marketplace health insurance policy, may receive assistance with the following co-payments, if the services are IN-NETWORK, OUTPATIENT, AND related to the client's HIV status, related co-morbidity, or complication of HIV treatment:
 - Physician or medical practitioner co-payments
 - In-network
 - Limited to ADAP-approved ACA health insurance plans
 - Laboratory/Diagnostic co-payments
 - In-network
 - Limited to ADAP-approved ACA health insurance plans
 - Prescription drug co-payments
 - This assistance is limited to medications found on the most current, local Ryan White Part A Program Prescription Drug Formulary. See the following web page:
<http://www.miamidade.gov/grants/ryan-white-program.asp#Prescription>
 - This assistance does NOT include medications found on the most current Florida ADAP Formulary.
 - IMPORTANT NOTE: Medications not available through the client's health insurance policy that are found on the most current, local Ryan White Part A Program Prescription Drug Formulary can be covered by the Part A Program. In such cases, the

client's medical case manager or external case manager must issue a Ryan White Program Certified Referral or Out of Network (OON) Referral (with appropriate back-up documentation), respectively, for the Part A Program prescription drug service category.

- **Co-payment assistance is limited to allowable services rendered in Miami-Dade County.**

B. Rules for Reimbursement: Providers will be reimbursed for dollars expended *per ACA co-payment per client, plus a dispensing rate.* Furthermore:

- Billing code **ACADRG** must be used for ADAP/Part A ACA Wraparound (ADAP ACA Transition List) clients for whom Part A is paying their allowable prescription drug co-payments (i.e., non-Florida ADAP Formulary medications).
- Billing code **ACAOV** must be used for ADAP/Part A ACA Wraparound (ADAP ACA Transition List) clients for whom Part A is paying their allowable doctor/medical practitioner office visit co-payments.
- Billing code **ACALAB** must be used for ADAP/Part A ACA Wraparound (ADAP ACA Transition List) clients for whom Part A is paying their allowable laboratory and diagnostic co-payments.

C. Additional Rules for Reporting: Monthly activity reporting for this service must be in dollars *per ACA ADAP/Part A Wraparound co-payment per client.* The service provider must also report the number of unduplicated clients served each month.

D. Additional Rules for Documentation: Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

LEGAL ASSISTANCE
(YEAR 26 Service Priority #12)

Legal Assistance is a support service. This service provides legal assistance to individuals living with HIV or AIDS who would not otherwise have access to these services with the goal of maintaining clients in health care. Legal assistance provides services to eligible individuals with respect to powers of attorney, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program, especially but not limited to assistance with access to benefits and health care-related services.

A. Program Operation Requirements: Funds may be used to support and complement pro bono activities. All legal assistance will be provided under the supervision of an attorney licensed by the Florida Bar Association. Only civil cases are covered under this Agreement. Therefore, the service provider will assist eligible Ryan White Program clients with civil legal HIV-related issues which will benefit the overall health of the client and/or the Ryan White Program care delivery system in the following areas:

- Collections/Finance – issues related to unfair or illegal actions by collection agencies related to health care debt (e.g., bankruptcy due to health care debt).
- Employment Discrimination Services – issues related to discrimination while at work, unfair terminations, unfair promotion policies, or hostile work environment as related to HIV diagnosis or status.
- Health Care Related Services – issues related to ensuring that the client is treated in a fair manner, and issues relating to breach of confidentiality by divulging HIV status or other confidential medical/income information without client consent.
- Health Insurance Services – issues related to seeking, maintaining, and purchasing of private health insurance.
- Government Benefit Services – issues related to obtaining or retaining public benefits which the client has been denied and is eligible to receive, including but not limited to Social Security Disability and Supplemental Income Services benefits, Unemployment Compensation, as well as welfare appeals, and similar public/government services.
- Rights of the Recently Incarcerated Services – issues related to a client’s right to access and receive medical treatment upon release from a correctional institution.

- Adoption/Guardianship Services – issues relating to preparation for custody options for legal dependents including guardianship, joint custody, or adoption.
- Permanency Planning – including the provision of legal counseling regarding the drafting of living wills, last will and testament, delegating powers of attorney, health care surrogate, advance directives, and estate planning.
- NOTE: Adoption/Guardianship and Permanency Planning activities do not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. Proper planning must occur prior to the death of the client (i.e., parent/guardian).

Providers should demonstrate experience in providing similar services and the ability to meet the multi-lingual needs of the HIV/AIDS community.

- B. Rules for Reimbursement:** The unit of reimbursement for this service is *one hour* of legal consultation and/or advocacy provided by an attorney or paralegal at a rate not to exceed \$90.00 per hour.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of *one hour of legal consultation and/or advocacy* provided by an attorney or paralegal. Legal assistance providers must submit an annual written assurance that 1) Ryan White Program funds are being used only for legal services directly necessitated by an individual's HIV status; 2) Ryan White Program funds are not used for any criminal defense or for class action suits unrelated to access to services eligible for Ryan White Program funding; and 3) the Ryan White Program was used as the payer of last resort.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated annually. Providers must also document that HIV+ clients receiving Ryan White Program Part A-funded legal assistance are permanent residents of Miami-Dade County and have gross household incomes that do not exceed 200% of the 2016 Federal Poverty Level (FPL).
- E. Additional Rules for Documentation:** Client charts must include a description of how the legal service is necessitated by the individual's HIV status, the provision of services, client eligibility (Ryan White Program Certified Referral or Out of Network Referral with supporting documentation), and the hours spent in the provision of such services.

MEDICAL CASE MANAGEMENT (General HIV/AIDS Population & MAI)
(YEAR 26 Service Priority #1 for Part A and MAI)

Medical Case Management is a core medical service. The Ryan White Program Medical Case Management service category has two (2) distinct components: **Medical Case Management and the Peer Education and Support Network (PESN)**. *Providers are required to offer both components of this service category.*

The Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) defines medical case management as a range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting clients to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare, Medicare Part D, State ADAP, pharmaceutical company Patient Assistance Programs, and other state and local health care and supportive services). Coordination and follow-up of medical treatments are also components of medical case management. Services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of clients' and key family members' needs and personal support systems. Medical case management includes treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatment regimens. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; (5) client-specific advocacy and/or review of service utilization; and (6) periodic re-evaluation and adaptation of the plan, at least every six (6) months, as necessary over the life of the client. This includes all types of case management encounters, including face-to-face meetings, telephone contacts, and any other documented forms of communication.

The purpose and goals of medical case management are: 1) to maintain the client in ongoing medical care and treatment; 2) to coordinate services across funding streams; 3) to reduce service duplication across providers; 4) to assist the client with accessing needed services; 5) to use available funds and services in the most efficient and effective manner; 6) to increase the client's adherence to the care plan (i.e., medication regimen) through counseling; 7) to empower clients to remain as independent as possible; 8) to improve service and client health outcomes; and 9) to control costs while ensuring that client needs are properly addressed.

MEDICAL CASE MANAGEMENT COMPONENTS

- I. *Medical Case Management:*** Medical case managers must be knowledgeable about the diversity of programs and be able to develop service plans from various funding streams. They are responsible for helping clients access needed services, not just Ryan White Program-funded services. Medical case managers will continue to have a training emphasis on addressing client housing issues (e.g.,

instability, homelessness, etc.) and identifying available housing assistance programs in Miami-Dade County.

Locally, medical case managers are responsible for performing the following functions: 1) conducting a full assessment of the client's medical, financial, social, and other needs (initial intake); 2) developing care plans including coordination and follow-up of medical treatment; 3) managing and coordinating services (referrals, assisting with initial appointments, and coordinating services identified in the care plan, etc.); 4) monitoring client adherence to the care plan and medication regimens, as well as ensuring that service providers involved in the client's care are rendering services as requested; 5) evaluating services provided to the client by all funding sources to determine consistency with the established care plan; 6) re-assessing and revising the care plan every six (6) months at a minimum for active clients, or more often as needed; 7) conducting secondary prevention; and 8) closing client cases when warranted and documenting the reason for case closure (including, but not limited to, case closures for clients with whom there has been no contact for more than 6 months). Medical case managers should run "Last Known Contact Report", "Client Assessment Due" and "Missing CD4/Viral Load Analysis" reports in the SDIS monthly to identify any clients who may be at risk for falling out of care, and follow-up as appropriate (including a referral to outreach services if allowable) to locate the client and bring them back into care. Medical Case Managers will manually close the case in the SDIS if they, and any outreach workers, are unable to locate a client who has had no face-to-face contact for six (6) months. The Service Delivery Information System (SDIS) will automatically close a client's case after twelve (12) months of no Ryan White Part A or Minority AIDS Initiative (MAI) funded service and no progress notes.

- II. Peer Education and Support Network (PESN):** At the option of the client, the medical case management agency will assign an HIV+ "Peer" (i.e., PESN, Case Aide, Peer Educator, Peer Navigator) to provide "peer support," including client orientation and education about health and social service delivery systems. The HIV+ Peer may assist with initial client intake, paperwork and applications for financial and medical eligibility, educating new clients on the process of accessing core and support services, as well as accompanying clients to initial appointments for medical care and other services. The HIV+ Peer may also make phone calls or send mail, including electronic mail, (where authorized by the client) to clients for the purpose of reminding them of medical appointments, in order to improve the client's attendance and reduce no-shows. Peers are restricted from completing Ryan White Program Certified Referrals, Plans of Care, and Comprehensive Health Assessments, as these are functions of a medical case manager. The HIV+ Peer may also provide stress management guidance to their clients. For a description of PESN Essential Functions see Section VII in these guidelines.

Support group meetings and related activities are not an allowable function of the local Peer Education and Support Network services.

The Peer will have basic knowledge of HIV/AIDS services and receive necessary training on HIV funding streams.

As incentives for productivity, providers are encouraged to provide the Peer with educational opportunities, as well as a standard living wage and medical benefits.

If the client decides not to access the PESN services, then the medical case manager will also be responsible for providing the following services: 1) presentation of information regarding the HIV service delivery system across funding streams, and 2) assistance to clients in preparing applications for other benefit programs.

The following requirements apply to both Medical Case Management and PESN services (including Minority AIDS Initiative services) as indicated:

- A. Program Operation Requirements:** Providers must ensure that medical case management services include, at a minimum, the following: peer support, assessment, follow-up, direction of clients through the entire system of health and support services, and facilitation and coordination of services from one service provider to another. Providers of medical case management services are expected to educate clients on the importance of complying with their medication regimen.

Medical case managers and Peers operate as part of the clinical care team and must maintain frequent contact with other providers (the client's physician, nutritionist, pharmacist, counselor, HOPWA housing specialist, etc.) and with the client in order to assure the client adheres to medication regimens and ensure that the client receives coordinated, interdisciplinary support for adherence, attendance at medical care appointments, picking up prescriptions and re-fills, and assistance in overcoming barriers to meeting treatment objectives.

Medical case management providers are expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and to ensure that immediate follow-up is available for clients who miss their prescription refills, physician visits, and/or who experience difficulties with adherence. Medical case management providers must ensure that the client is knowledgeable about HIV/AIDS; understands CD4 count, viral load, adherence and resistance concepts; understands the reason for treatment; identifies and addresses the possible factors or barriers affecting treatment adherence; and understands his/her treatment regimen to the best of the client's ability.

1. **Medical Case Manager Qualifications:**

Providers of this service will adhere to the educational and training requirements of staff as detailed in the *Ryan White Program System-wide Standards of Care* and the *Ryan White Program Medical Case Management Standards of Service* (see Section III of this book).

2. **Provider Requirements:**

a) **Contractual.** Providers will be expected to report to Miami-Dade County the following:

- An explanation of the training, including cultural sensitivity issues, that will be offered to case management staff, including "peers."
- An explanation of how a client's adherence to treatment will be monitored and how adherence problems will be identified and resolved.
- An explanation of how the provider will serve clients who speak English, Spanish, and Creole or who have limited language proficiency. **Medical case management providers must budget for the following expenses or otherwise accommodate client needs for: American Sign Language interpreter, foreign language interpreter, Braille, and other materials to accommodate clients with disabilities, limited English language proficiency, and/or low literacy levels.**
- A description of linkage agreements in place with other HIV/AIDS service providers.

b) **Required Forms.** Medical case management staff will utilize Ryan White Program standardized forms, as approved by the Miami-Dade HIV/AIDS Partnership and the County, for all medical case management functions.

c) **Referrals.** All referrals made by Part A or MAI-funded medical case managers to Ryan White Program services must be made utilizing the Ryan White Program Certified Referral process, which is available through the Service Delivery Information System (SDIS). Referrals cannot be made for services not documented in the client's Plan of Care. However, in the case of emergency, a Plan of Care may be amended within two (2) business days to allow for the referral. Referrals for non-Part A or non-MAI services made by Part A/MAI medical case managers

will use the general certified referral form in the Service Delivery Information System (SDIS). Referrals made to Part A/MAI services by non-Part A or non-MAI funded case managers will use the Out-of-Network (OON) general certified referral form available from the County's Office of Management and Budget-Grants Coordination – Ryan White Program. The OON referral must be accompanied by appropriate supporting documentation and signed consents.

- d) **Caseload.** Medical case managers should have an active caseload of no more than 70 clients. Clients limited to only "situational needs" should not be included in the "active" caseload count.
- e) **Peer schedules.** Providers are reminded that some "peer" workers may be eligible for disability income and/or other supplemental income. Consequently, a part-time work schedule should be well-planned to meet the needs and benefits of the peer employee.
- f) **Comprehensive Health Assessments.** Medical case managers are expected to complete a Comprehensive Health Assessment annually for each client. However, brief updates should be conducted at 6-month intervals in conjunction with the client's re-certification process (See Section III of this book, Miami-Dade County Ryan White Program Medical Case Management Standards of Service, Standard #7, NOTE).
- g) **Progress Notes.** Services must be documented in progress notes in a timely manner, preferably within 24 hours of service, but no later than 48 hours after occurrence. Any medical case management or Peer Education and Support Network encounter not properly recorded in the Service Delivery Information System (SDIS) within 48 hours (i.e., 2 business days) will be rejected in the SDIS. Requests for an override related to this type of rejection may be submitted to Miami-Dade County-Office of Management and Budget/Ryan White Program for review. A reasonable justification for the delay in recording an encounter in the SDIS must be included for review of related override requests. Depending on the agency's reason for the delay, the County may opt to disallow the encounter.

A reasonable justification for the delay in entering a timely progress note would include the following, if such reason caused the medical case manager, peer educator, or the medical case manager supervisor to miss the 48-hour time limit for entering progress notes:

- An event beyond the medical case manager, peer educator, or medical case manager supervisor's control, such as an illness, proven data system (e.g., SDIS) access issues, or extreme weather event directly affecting program operations.
- A documented and previously approved event such as the aforementioned staff persons' vacation or attendance at a Ryan White Program meeting or training.

B. Additional Service Delivery Standards: Providers of this service will adhere to the *Ryan White Program Medical Case Management Standards of Service*. (Please refer to Section III of this book for details.)

C. Rules for Reimbursement: The units of service used for medical case management and PESN reimbursements are as follows. (*NOTE: except for OMB-GC, HIV/AIDS, SDIS, HIPAA, and PESN, all acronyms used in this section are billing codes.*)

1. *Medical Case Management Services* are reimbursed by unit cost, where one unit equals one minute of actual time, at rates not to exceed \$1.00 per unit/minute. Each funded providers' corresponding price form breaks down the allocation for this service into "Face to Face encounters" (FFE) or "Other encounters". Other encounters are defined as any non-FFE contact with or on behalf of the client. See table below.
2. *Peer Education and Support Network (PESN) Services* are reimbursed by unit cost, where one unit equals one minute of actual time, at rates not to exceed \$0.50 per unit/minute. Each funded providers' corresponding price form breaks down the allocation for this service into "Face to Face encounters" (FFE) or "Other encounters". Other encounters are defined as any non-FFE contact with or on behalf of the client. See table below.
3. Providers are required to document in the client's chart each unit of service performed (including the type of encounter and length of time spent) as face-to-face encounters or activities conducted on behalf of a client. Units of service must be documented and reported separately for PESN and medical case management services.
4. Client eligibility screening for voucherable services is billable as a unit of service depending on the amount of time spent with the client. Costs related to the distribution of voucher services should be covered under the dispensing charge allowed for handling of vouchers under the transportation voucher service category (i.e., discounted transportation EASY Tickets).

5. The following table reflects MCM and PESN encounter/activity billing codes (in alphabetical order) that will be active in FY 2016:

| Medical Case Management & PESN* | | |
|---|---|---|
| Activity (with Limitation, if applicable) | Encounter/ Activity Billing Code | Comment, Limitation, etc. |
| Affordable Care Act Health Insurance Marketplace | ACA | Includes any and all activities with or on behalf of the client, such as researching health insurance plans, discussing plan options, assisting with the application process, and documenting all efforts, related to the client's enrollment in private insurance through the Affordable Care Act Health Insurance Marketplace. This code also includes time spent explaining the plan to client, how it works, what documents the client is required to present, what benefits and restrictions the client has under the plan. Do NOT use this code to record time spent actually enrolling client in an ACA Marketplace health insurance plan (i.e., activities spent navigating or enrolling clients on-line in www.healthcare.gov are not billable to the local Ryan White Program). |
| Adherence Counseling | ADH | Includes activities with the client such as medication counseling, risks and benefits of treatment, compliance with treatment regimen, education on resistance, compliance with medical and other core service appointments, and review of HIV case management portal information. |
| Case Closure Activity | CCA | Includes activities related to closing a client's case at the agency and in the SDIS. The limit in the SDIS for this activity per client is 30 units (i.e., 30 minutes; see "Definition of a Unit" below). |

| Medical Case Management & PESN* (cont'd) | | |
|--|---|---|
| Activity (with Limitation, if applicable) | Encounter/ Activity Billing Code | Comment, Limitation, etc. |
| Collateral Contacts | COL | <p>Includes communication with other care providers outside of the provider agency for coordination of care activities. Includes telephone contacts or other electronic methods of communication (e.g., email or fax) with the outside entity to obtain or provide additional information for the client's care.</p> <p>This code should NOT be used for:</p> <ul style="list-style-type: none"> • Internal agency communication, collaboration or case reviews. <i>[Use REV and/or CON instead; limited to use by authorized MCM staff only (i.e., supervisors & lead case managers)]</i> • Pulling a chart to copy documents for a client's personal use or for filing. <i>[Use FFE or DOC instead, as applicable]</i> • Plan of Care activities <i>[Use POC instead]</i> |
| Consulting w/ Staff | CON | Includes activities related to case consultation with internal staff. This code may ONLY be billed by the agency's OMB-GC-authorized MCM Supervisor or Lead Medical Case Manager. |
| Documentation | DOC | <p>Includes activities related to documenting any encounter in the SDIS, such as the progress note, face-to-face encounter, telephone contact, etc. This service code also includes time spent filing or organizing the client chart or pulling the chart to make copies that are unrelated to coordination of care for the client.</p> <p>This code also includes conducting peer reviews of client charts.</p> <p>Do <u>not</u> use this DOC code to record documentation of activities related to the client's care plan. Instead use POC to record <u>any</u> Plan of Care activity.</p> |

| Medical Case Management & PESN* (cont'd) | | |
|--|---|--|
| Activity (with Limitation, if applicable) | Encounter/ Activity Billing Code | Comment, Limitation, etc. |
| Eligibility Specialist (with Bachelor's Degree) | ESM | For use by OMB-GC authorized Eligibility Specialists only who have educational qualifications similar to a Ryan White Program medical case manager (i.e., bachelor's degree) (billable at \$1.00 per minute). This code is to be used only by authorized persons completing Ryan White Program eligibility and facilitating the financial eligibility review process at Jackson Health System for purposes of assisting eligible clients in obtaining a Jackson Health System/Jackson Memorial Hospital "J card" with the "IO1" designation of the Ryan White Program as the payer source. |
| Eligibility Specialist (no degree) | ESP | For use by OMB-GC authorized Eligibility Specialists only who do NOT have educational qualifications similar to a Ryan White Program medical case manager (i.e., no degree) (billable at \$0.50 per minute). This code is to be used only by authorized persons completing Ryan White Program eligibility and facilitating the financial eligibility review process at Jackson Health System for purposes of assisting eligible clients in obtaining a Jackson Health System/Jackson Memorial Hospital "J card" with the "IO1" designation of the Ryan White Program as the payer source. |
| Face-to-Face Encounter | FFE | This encounter is defined as any time the medical case manager, peer, or medical case manager supervisor has direct contact with the client in person. In consultations with a child and one or more adults, encounters are billed for one family member only who must be HIV+ and eligible for Ryan White Program-funded services. FFE includes activities that are conducted face-to-face with the client where no other encounter code is appropriate. FFE may also include referral activities if done face-to-face with the client. |

| Medical Case Management & PESN* (cont'd) | | |
|--|---|---|
| Activity (with Limitation, if applicable) | Encounter/ Activity Billing Code | Comment, Limitation, etc. |
| Newly Identified Clients | NIC | <p>The NIC code is to be used for newly identified HIV+ clients in advance of confirming client eligibility for local Ryan White Program services. Prior to completing a formal Ryan White Program Intake and Assessment for newly identified HIV+ clients, a total of up to three (3) visits with either a medical case manager or a peer educator/counselor within a 30 calendar day period may be billed to the Ryan White Program.</p> <p>These visits are to be used for 1) providing supportive counseling and support in preparation for linkage to care (i.e., connection to a medical provider), 2) assisting the client in gathering documentation to confirm program eligibility in order to link these clients to outpatient primary medical care or medical case management services, and 3) referring the client to a medical provider for an initial medical visit.</p> <p>The billing code “NIC” should be used to record such services to newly identified HIV+ clients only. The limit in the SDIS for this activity is a maximum of 3 encounters, to be completed <u>within</u> a 30 calendar day period.</p> <p>NOTE: Newly identified clients may be linked to care using the NIC code as indicated directly above; however, services funded by Ryan White Program dollars will either continue or cease for the client depending on the results from the confirmatory HIV test.</p> |
| Electronic Override Activity | OVR | <p>This code may ONLY be used by authorized MCM Supervisors or Lead Case Managers. The limit in the SDIS for this activity per client is 30 units (i.e., 30 minutes; see “Definition of a Unit” above).</p> |

| Medical Case Management & PESN* (cont'd) | | |
|--|---|--|
| Activity (with Limitation, if applicable) | Encounter/ Activity Billing Code | Comment, Limitation, etc. |
| Plan of Care | POC | This code is to be used by medical case managers or medical case management supervisors to record all Plan of Care activities (including the initial creation of the POC, the 6-month review, ongoing updates, follow-up, and related referrals). Peers and medical case management assistants are not authorized to create or update the POC. |
| Plan of Care Update | PCU | This code is discontinued effective May 1, 2016 . Use POC for all Plan of Care activities instead. |
| Chart Review | REV | Includes activities related to reviewing client charts for quality management purposes, to ensure proper documentation and coding. This code may ONLY be billed by the agency's OMB-GC-authorized MCM Supervisor or Lead Medical Case Manager. |
| Telephone Encounter | TEL | Includes telephone contacts with the client or the client's representative, or leaving a voice message for the client. This activity does not include telephone contacts with other care providers. NOTE: Telephone contacts with other care providers, for the purpose of coordinating care for clients, should be recorded as a collateral (COL) encounter (see above). |

| Medical Case Management & PESN* (cont'd) | | |
|--|---|--|
| Activity (with Limitation, if applicable) | Encounter/ Activity Billing Code | Comment, Limitation, etc. |
| RW-Approved Training | TRN | Includes time spent at local Ryan White Program-approved training for Medical Case Managers, Peer Educators, MCM Supervisors, and Outreach Workers, such as monthly case management and case management supervisor trainings, Service Delivery Information System trainings, and quarterly Ryan White Program Provider Forums. The TRN code may not be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code <u>cannot</u> be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, on-site technical assistance provided by Behavioral Science Research Corporation (the Program's contracted quality management provider), appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, or other employer-required training. Travel time is not included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code. |

***NOTES:**

- 1) There is no special billing code or activity code for ADAP-related services. ADAP-related services should be coded with the appropriate code from the table above.
- 2) MCM Supervisor direct service duties include activities related to, with, or on behalf of a client such as maintaining their own client case load, conducting case consultation with the medical case manager for complex client issues or problems, and assisting the medical case manager or client with the client's treatment adherence issues and/or other problems related to appropriate care.
- 3) MCM Supervisor administrative duties include staff scheduling, payroll, performance evaluations, general supervision, training unrelated to Ryan White Program activities, and other non-client related services. Do NOT use the billing codes above to record general administrative activities.

- D. Rules for Reporting:** Providers of PESN and medical case management services must report, separately, their monthly activities according to one-minute "Face-to-Face" encounters and one-minute "Other" encounters. In addition, providers must report the number of unduplicated clients served. Providers must develop a method to track and report client wait time (e.g., the time it takes for a client be scheduled to see a medical case manager after calling for an appointment; and upon arrival for the appointment, the time the client spends waiting to see the medical case manager) and to make such reports available to OMB-GC staff or authorized persons upon request.
- E. Applicability to Local Ryan White Program Requirements:** If a staff person of a Ryan White Program-funded service provider has a Ryan White Program medical case management caseload, even one client, they will be required to adhere to the local Ryan White Program Service Delivery Guidelines, Medical Case Management Standards of Service, and Quality Management Program activities, whether or not they appear on the program's line item budget and regardless of the percentage of time and effort spent performing Ryan White Program medical case management activities. Similarly, if they supervise any Ryan White Program medical case management staff, whether or not they are on the budget for such, they also must follow the requirements in the local Ryan White Program Service Delivery Guidelines, Standards for Medical Case Management Supervisors, and Quality Management Program requirements.
- F. Additional Rules for Documentation:** Providers must also maintain documentation to support educational requirements in the personnel records for medical case management staff and ensure that such documentation is available for review by authorized persons.

MENTAL HEALTH THERAPY/COUNSELING
(YEAR 26 Service Priority #5)

Mental Health Therapy/Counseling is a core medical service. This service offers non-judgmental psychological and psychiatric treatment and counseling services for HIV+ persons who have a diagnosed mental illness. These services may be conducted in an individual or group setting by mental health counseling professionals who are licensed or authorized with the State of Florida to render such services. Mental health therapy/counseling sessions may only be provided in an outpatient setting. **Please note that Ryan White Program funds may not be used for bereavement support for uninfected family members or friends.**

Mental health therapy/counseling services reimbursed under Part A of the Ryan White Program are limited to conditions stemming from and treated within the context of the client's HIV or AIDS diagnosis. This service is intended to address HIV-related issues and strengthen coping skills to increase adherence and access to on-going medical care and treatment. It is important for the Level I or Level II mental health professional to regularly gauge the client's progress, and determine if the client is still in need of the service.

- **Mental Health Therapy/Counseling (Level I)** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess *postgraduate degrees* in psychology or counseling (PhD, EdD, Psy.D) and must be *licensed by the State of Florida* as a Licensed Clinical Psychologist, LCSW, LMHC, or LMFT to provide such services.
- **Mental Health Therapy/Counseling (Level II)** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess *Master's degrees* in psychology, psychotherapy or counseling (MS, MA, MSW, or M.Ed.), and must be *licensed by the State of Florida* as a LCSW, LMHC or LMFT to provide such services. Direct service providers may also be 1) Florida registered interns as defined by Florida Statute (F.S.) 491.0045 (clinical social work intern, mental health counselor intern, or marriage and family therapy intern), or 2) a psychology intern, postdoctoral resident, or fellow satisfying Rule 64B19-11.005 of the Florida Administrative Code (F.A.C.). Such interns will provide services under the supervision of a licensed State of Florida LCSW, LMHC, LMFT or licensed psychologist to provide such services.

Mental Health Therapy/Counseling Components:

Counseling services (**Level I**) provided to clients by licensed professionals will include psychosocial assessment and evaluation, testing, diagnosis, treatment planning with written goals, crisis counseling, periodic re-assessments, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

Counseling services (**Level II**) include crisis counseling, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

Group Counseling (Levels I and II) – refers to a group of individuals [minimum of three (3) Ryan White clients, maximum of fifteen (15) total clients] with similar problems meeting under the expert guidance of a trained mental health professional. Members of the group will be selected by the mental health professional in order to maximize the interaction, learning, and benefits derived from a group dynamic. Group counseling provides therapy in a social context, reduces the feeling of isolation many clients experience, provides an opportunity for clients to share methods of problem-solving, and allows the therapist an opportunity to observe how an individual interacts with others.

- A. Program Operation Requirements:** Staff must demonstrate knowledge of HIV disease, its psychosocial dynamics and implications, including cognitive impairment, and generally accepted treatment modalities and practices. Services may be delivered to non-HIV+ family members (as defined by the client) only if the HIV+ client is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of support group participants to counselors may not be lower than 3:1 and may not be higher than 15:1. One visit is equal to one half-hour counseling session.

- B. Additional Service Delivery Standards:** Level I and Level II providers must adhere to generally accepted clinical guidelines for psychological treatment of persons with HIV/AIDS-related illnesses. (Please refer to Section III of this book for details.)
- C. Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half-hour counseling session not to exceed \$32.50 per unit for Level I individual counseling; \$35.00 per unit for Level I group counseling; \$32.50 per unit for Level II individual counseling; and \$35.00 per unit for Level II group counseling. Reimbursement for individual counseling units are calculated for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are calculated for the counselor that provided the group therapy (i.e., number of group counseling units per counselor).
- D. Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a one-half-hour counseling session and the unduplicated number of clients served. Providers will report individual and group activity separately for Level I and Level II mental health therapy/counseling services.
- E. Additional Rules for Documentation:** Providers must also maintain certifications and licensure documents of the mental health professionals providing services to Ryan White Program clients, and must make these documents available to OMB-GC staff or authorized persons upon request. Client charts must include a detailed treatment plan for each eligible client that includes required components and the mental health professional's signature.

ORAL HEALTH CARE
(YEAR 26 Service Priority #6)

Oral Health Care is a core medical service. This service includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide dental care in the State of Florida, including general dental practitioners, dental specialists, and dental hygienists, as well as trained dental assistants. This service may include diagnostic, preventive, and restorative services; endodontics, periodontics, and prosthodontics (removable and fixed); maxillofacial prosthetics; implant services (limited to removal of implant or repair of implant abutment); oral and maxillofacial surgery; and adjunctive general services as detailed in the most current, local Ryan White Program Oral Health Care Formulary.

- A. Program Operation Requirements:** Provision of oral health care services for any one client is limited to an annual cap of \$5,000 per the Ryan White Part A Fiscal Year (March 1, 2016 through February 28, 2017). Very limited exceptions to the annual cap may be approved by the County, with consultation from the Miami-Dade HIV/AIDS Partnership's Ad Hoc Oral Health Care Committee as needed, on a case-by-case basis for the provision of preventive oral health care services only.

Clients referred for oral health care by a Ryan White Part A or MAI medical case manager require a Ryan White Program Certified Referral Form, as approved by the Miami-Dade HIV/AIDS Partnership and the County. If the client is referred by a non-Part A or non-MAI provider ("Out of Network" provider), an OON general certified referral form must be submitted accompanied by the required medical, financial, and permanent Miami-Dade County residency documentation as well as all required consent forms and Notice of Privacy Practices. Clients coming without a referral, but with necessary supporting documentation, are also able to access Ryan White Part A oral health care services, upon completion of a brief intake in the SDIS by the oral health care provider agency and the client's signed consent for service.

When a referral from a dentist to a dietitian is needed, the dentist must coordinate with the client's primary care physician to obtain the required referral to nutrition services (i.e., a referral to Ryan White Program outpatient specialty care services). This is necessary to ensure communication between the care team (e.g., physician and dentist). The client's medical case manager should also be informed of the client's need for nutrition services.

Providers must offer, post, and maintain a daily walk-in slot for clients with urgent/emergent dental issues. Clients who come into or contact the office with urgent/emergent dental issues (e.g., pain, broken tooth, situation requiring immediate treatment, or situation causing client high level of distress) will be triaged by appropriate dental staff; and those clients with

substantial issues will be seen as soon as possible, but within 48 hours (i.e., two business days).

B. Additional Service Delivery Standards: Providers of this service will adhere to the most current, local *Ryan White Program System-wide Standards and Ryan White Program Oral Health Care Standards*. (Please refer to Section III of this book for details.) Providers will be required to demonstrate that they will adhere to generally accepted clinical guidelines for oral health care treatment of HIV and AIDS-specific illnesses.

C. Rules for Reimbursement: Providers will be reimbursed for all routine and emergency examination, diagnostic, prophylactic, restorative, surgical and ancillary oral health care procedures, as approved by the Miami-Dade HIV/AIDS Partnership and included in the most current Ryan White Program Oral Health Care Formulary using the 2016 American Dental Association Current Dental Terminology (CDT 2016) codes for dental procedures.

The reimbursement structure for this service category is currently under review. Until this review, including market research and a cost analysis, is complete, reimbursement rates will remain the same as indicated in the FY 2015 Oral Health Care Formulary. If a procedure has a 2016 Medicaid rate (from the State of Florida Medicaid Dental General Fee Schedule, dated January 1, 2016), the reimbursement rate will be updated accordingly. If a Medicaid rate is indicated, a 3.0 multiplier will be applied. Providers will be notified of any changes to the reimbursement structure prior to implementation.

An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form.

D. Children's Eligibility Criteria: Providers must document that HIV+ children who receive Part A-funded oral health care services are permanent residents of Miami-Dade County and have been properly screened for Medicaid and other public sector funding (i.e., the Medically Needy Program), as appropriate. While children qualify for and can access Medicaid or other public sector funding for oral health care services, they will not be eligible for Ryan White Part A-funded oral health care services, except those tests or procedures excluded by Medicaid.

E. Ryan White Program Oral Health Care Formulary: Ryan White Part A funds may only be used to provide oral health care services that are included in the most recent release of the most current, local Ryan White Program Oral Health Care Formulary. The Formulary is subject to periodic revision.

F. Rules for Documentation: Providers must maintain a dental chart or electronic record that is signed by the licensed provider (e.g., dentist, etc.) and includes a treatment plan, dates of service, services provided, procedure codes billed, and any referrals made. Providers must also maintain professional certifications and

licensure documents of the dental staff providing services to Ryan White Program clients, and must make these documents available to OMB-GC staff or authorized persons upon request.

- G. Rules for Reporting:** Provider monthly reports for oral health care must include the number of clients served, billing code for the dental procedures provided, number of units of service provided, and the corresponding reimbursement rate for each service provided. Providers must also develop a method to track and report client wait time (e.g., the time it takes for a client be scheduled to see the appropriate dental provider after calling for an appointment; and upon arrival for the appointment, the time the client spends waiting to see the dental provider) and to make such reports available to OMB-GC staff or authorized persons upon request.

OUTPATIENT MEDICAL CARE (General HIV/AIDS Population & MAI)
(YEAR 26 Service Priority #2 for Part A and MAI)

- A. **Outpatient Medical Care** is a core medical service. This service includes primary medical care and outpatient specialty care required for the treatment of individuals living with HIV or AIDS. It focuses on timely/early medical intervention and continuous health care and disease treatment and management over time. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service (PHS) guidelines. Such care must include access to antiretroviral (ARV) and other drug therapies, including prophylaxis and treatment of opportunistic infections (OI) and combination ARV therapies.

IMPORTANT NOTE: Services are restricted to outpatient services only.

The relationship of the following services to a client's HIV diagnosis, co-morbidity, or complication related to HIV treatment must be clearly documented in the client's medical chart, in the primary care physician's referral to specialty care services, and in any corresponding Ryan White Program Certified Referral or general Out of Network Referral. Miami-Dade County's clarification letter and electronic mail messages regarding notations of HIV-related outpatient medical care referrals, dated December 20, 2013, March 3, 2014, and October 28, 2015, including a list of allowable medical conditions (see Section VIII of this book for a copy of this list), as may be amended, are incorporated herein by reference. For clarity, one or more of the listed conditions from this sample list along with one of the following catch-phrases should be included in the physician's notation and related referral, as appropriate:

- Service is in relation to this client's HIV diagnosis.
- Service is needed due to a related co-morbidity.
- Service is needed due to a condition aggravated or exacerbated by the client's HIV.
- Service is needed due to a complication of this client's HIV treatment.
- Routine diagnostic test conducted as a standard of care (SOC) as recommended by established medical guidelines, including, but not limited to, Public Health Service (PHS), American Medical Association, Health Resources and Services Administration, see Minimum Primary Medical Care Standards for Chart Reviews in Section III of this Service Delivery Guidelines document or other local guidelines.

I. Primary Medical Care

- 1. Primary Medical Care Definition and Functions:** Primary medical care includes the provision of comprehensive, coordinated, professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, advanced registered nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe ARV therapy in an outpatient setting. Outpatient settings include clinics, medical offices, and mobile vans where clients in general do not stay overnight. **Emergency room services are not considered outpatient settings, and are not covered. Inpatient services are also not covered.** Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, continuing care and management of chronic conditions, and referral to and provision of specialty care (including all medical subspecialties if related to the client's HIV diagnosis), as necessary. Chronic illnesses usually treated by primary care providers include hypertension, heart failure, angina, diabetes, asthma, COPD, depression, anxiety, back pain, thyroid dysfunction, and HIV.

One (1), initial primary medical care visit may be provided to a newly identified client who has a preliminary reactive test result and a pending confirmatory HIV test result, if the client was properly referred by a medical case manager or outreach worker. To be valid for this purpose, the referral must have an indication that the client is a "newly identified client" (NIC). Such initial primary medical care visit must be scheduled and provided within 30 calendar days of referral from the medical case manager or outreach worker. Otherwise, a confirmatory HIV test result will be required to obtain further services.

If a phenotype lab test is needed, *a Ryan White Program Letter of Medical Necessity, completed by a physician, for Antiretroviral Phenotype including Phenosense Resistance Assays for Experienced Patients* is required. Note: genotype tests with or without Virtual Phenotype tests do not require a Letter of Medical Necessity.

Before prescribing Selzentry (Maraviroc), a Highly Sensitive Tropism Assay (test), formerly known as the Trofile Tropism Assay, must be performed and documented in the client's chart to determine appropriateness of the treatment regimen. The Highly Sensitive Tropism Assay includes the Trofile, Trofile DNA, or Quest Diagnostics Tropism assay. If the cost of the Highly Sensitive Tropism Assay is being covered by ViiV Healthcare's Tropism Access Program (TAP) (<https://www.viihcdxresource.com/TropismTesting/TAP>) or any other payment source, clients must access the test through those resources first.

Only when the cost of the Highly Sensitive Tropism Assay is no longer covered by ViiV Healthcare's TAP or any other source, then the medical providers must verify and document on the corresponding Ryan White Program Letter of Medical Necessity that the client has been found to be ineligible for the test to be paid for by any other payment source.

Another test currently covered by ViiV Healthcare at no charge to eligible clients or the Ryan White Program is the HLA-B*5701 screening test. This screening test is available to assist clinicians in identifying clients who are at risk of developing a hypersensitivity reaction to abacavir (Ziagen). Information regarding ViiV Healthcare's HLA-Aware™ Program for the HLA-B*5701 screening test can be found at the following webpage: <https://www.viihcsxresource.com/>. Whenever the cost of the HLA-B*5701 screening test can be covered by the ViiV Healthcare or any other source, providers cannot bill the local Ryan White Program for reimbursement of this test.

The Ryan White Program must be the payer of last resort. Utilization of these tests (Highly Sensitive Tropism Assay and HLA-B*5701 screening test) as billed to the local Ryan White Program will be monitored, and reimbursement may be denied if documentation does not support the use of Ryan White Program funds as a last resort.

2. **Client Education:** Providers of primary medical care services are expected to provide the following basic education as part of client care:
 - Treatment options, with benefits and risks, including information about state of the art combination drug therapies and reasons for treatment;
 - Self-care and monitoring of health status;
 - HIV/AIDS transmission and prevention methods; and
 - Significance of CD4 counts, viral load and related disease aspects, adherence and resistance concepts.

3. **Adherence Education:** Providers of primary medical care services are responsible for assisting clients with adherence in the following ways:
 - Adherence with medication regimens in order to reduce the risk of developing and spreading a resistant virus and to maintain health;
 - Taking medications as prescribed and following recommendations made by physicians, nutritionists, and pharmacists;

- Client involvement in the development and monitoring of treatment and adherence plans; and
- Ensuring immediate follow-up with clients who miss their prescription refills, physician appointments, and/or who experience difficulties with adherence.

4. Coordination of care: Providers of primary medical care services are responsible for ensuring continuity and coordination of care. They must:

- Maintain contact as appropriate with other caregivers (medical case manager, nutritionist, specialty care physician, pharmacist, counselor, etc.) and with the client in order to monitor health care and treatment adherence;
- Ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives; and
- Identify a single point of contact for medical case managers and other agencies that have a client's signed consent and other required information.

5. Additional primary medical care services may include:

- Respiratory therapy needed as a result of HIV infection.

II. Outpatient Specialty Care

- 1. Outpatient Specialty Care Definition and Functions:** This service covers short-term ambulatory treatment of specialty medical conditions and associated diagnostic procedures for HIV+ clients who are referred by a primary care provider through a Ryan White Program Certified Referral, OON referral, or prescription referral. Specialty medical care includes cardiology, chiropractic, colorectal, clinical psychiatry, dermatology, ear, nose and throat/otolaryngology, endocrinology, gastroenterology, hematology/oncology, hepatology, infectious disease, orthopedics/rheumatology, nephrology, neurology, nutritional assessments or counseling (performed by a registered dietitian), obstetrics and gynecology, ophthalmology/optometry, pulmonology, respiratory therapy, urology, and other specialties **as related to the client's HIV diagnosis or co-morbidities (see Allowable Medical Conditions List in Section VIII of this Service Delivery Guidelines document)**. Additional medical services may include outpatient rehabilitation, podiatry, physical therapy, occupational therapy, and speech therapy as related to the client's HIV diagnosis or co-morbidities. Pediatrics and specialty pediatric care are included in the list of specialties above.

(NOTE: Referrals to outpatient specialty care services should include documentation or a notation to support the specialty's relation to the client's HIV diagnosis or co-morbidity.)

Chiropractic services under the Ryan White Program are limited to pain management services in relation to a client's HIV diagnosis. Since Chiropractors specialize in the nervous system, adjustments to the spine/body that can assist the nervous system in operating to the best of its ability to fight HIV-related infection and disease will be covered by the County's Ryan White Program. However, chiropractic services for non-HIV related injuries or conditions (e.g., car accidents, slip and fall, sports injuries, etc.) are not covered by the County's Ryan White Program.

Podiatry services under the County's Ryan White Program are limited to services in relation to a client's HIV diagnosis or co-morbidity (e.g., diabetes). For example, podiatry services for the treatment of peripheral neuropathy, HIV-related medication side effects (e.g., HAART/protease inhibitor medication regimens may cause ingrown toenails), and diabetic circulatory problems will be covered by the County's Ryan White Program. However, general podiatry services for non-HIV-related or non-diabetic-related foot injuries or conditions are not covered by the County's Ryan White Program.

Optometry and ophthalmology services under the Ryan White Program are also limited to services in relation to a client's HIV diagnosis or co-morbidity. For example, an annual eye exam for the purpose of routine eye care (especially for vision correction with glasses or contact lenses) is not covered by the local Ryan White Part A/MAI Program. On the contrary, eye exams for patients with Microsporidiosis, Cytomegalovirus (CMV) disease, or Cytomegalovirus Retinitis (as indicated in Table 2 of the Department of Health and Human Services Treatment Guidelines for Opportunistic Infections, which can be found at https://aidsinfo.nih.gov/contentfiles/lvguidelines/Adult_OI.pdf) may be covered, IF there is an appropriate referral from the primary care practitioner, an active CPT code for the procedure, and a corresponding Florida Medicare reimbursement rate.

Per Federal guidelines, acupuncture services are not covered under this service category, as Ryan White Program funds may only be used to support limited acupuncture services for HIV+ clients as part of substance abuse treatment services.

Although the selection of a Ryan White Program-funded service provider is based on client choice, whenever possible, pregnant women should be referred to the University of Miami OB/GYN Department (Ryan White Part D Program, etc.) due to its specialized care for this HIV population. Furthermore, whenever possible and also based on client choice, providers are strongly encouraged to refer clients who are 13 to 24 years of age to the University of Miami's pediatric

and adolescent care departments (i.e., Project SMILE) due to their specialized care for this HIV population and age group.

Note: primary medical care provided to persons with HIV disease is not considered specialty care.

2. Client Education: Providers of specialty care services will be expected to provide the following basic education as part of client care:

- Basic education to clients on various treatment options offered by the specialist;
- Taking medications pertaining to specialty care treatment as well as adhering to treatment recommendations made by the primary care physician; and
- Educating clients about HIV/AIDS and its relationship to the specialty care service being provided.

3. Coordination of Care: The specialist must communicate, as appropriate, with the primary care physician and client for results, follow-up, and/or to re-evaluate the client in order to coordinate treatment.

B. Program Operation Requirements (for both Primary and Specialty Care):

- Providers must offer, post, and maintain walk-in hours to ensure maximum accessibility to outpatient medical care, to ensure that medical services are available to clients for urgent/emergent issues;
- Providers must demonstrate a history and ability to serve Medicaid and Medicare eligible clients; and
- For Primary Care Only: Providers must ensure that medical care professionals: 1) have a minimum of three (3) years of experience treating HIV clients; or 2) have served a high volume of HIV+ clients (i.e., >50% of individual caseload per practitioner) in the past year. Certification from the American Academy of HIV Medicine (AAHIVM) is encouraged, but not required.

Additionally, for outpatient specialty care only:

- A referral from the client's primary care physician is required for all specialty care services.

C. Additional Service Delivery Standards: Providers of these services will also adhere to the following guidelines and standards (please refer to Section III of this book for details)

- Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses (as amended and current)
- **HAB HIV Performance Measures to include the following, as may be amended:**
 - Core
 - All Ages
 - Adolescent/Adult
 - HIV-Infected Children
 - HIV-Exposed Children
 - Medical Case Management
 - Oral Health Care
 - AIDS Drug Assistance Program (ADAP)
 - Systems-Level
 - Frequently Asked Questions
- Minimum Primary Medical Care Standards for Chart Review

D. Rules for Reimbursement: Providers will be reimbursed for outpatient primary medical care and specialty care services as follows:

- Reimbursements for medical procedures and follow-up contacts to ensure client’s adherence to prescribed treatment plans will be no higher than the rates found in the “2016 Florida Medicare Part B Physician Fee Schedule (Participating, Locality/Area 04), modified January 8, 2016.”
- Reimbursements for medical procedures performed at Ambulatory Surgical Centers (ASC) will be no higher than the rates found in the “2016 Florida Medicare Part B ASC Fee Schedule, by HCPCS Codes and Payment Rates, modified January 20, 2016; for Core Based Statistical Area 33124 (Miami, FL).” (Applies only to organizations with on-site or affiliated Ambulatory Surgical Centers).
- Reimbursements for medical procedures performed at Outpatient Hospital centers will be no higher than the rates found in the approved “Medicare Addendum B Outpatient Prospective Payment System (OPPS) by HCPCS Code for CY 2016 (January 2016), dated December 14, 2015.” (Applies only to organizations with on-site or affiliated outpatient hospital centers).

- Evaluation and management visits and psychiatric visits will be reimbursed at rates no higher than the Medicare “allowable” rates times a multiplier of up to 1.5.
- Reimbursements for lab tests and related procedures will be based on rates no higher than those found in the “2016 Medicare Clinical Diagnostic Laboratory Fee Schedule, for Florida (FL), revised for January 2016, dated December 15, 2015.” If the client is eligible for ADAP, that program should be accessed for genotype and phenotype testing if available. A Letter of Medical Necessity is required for Ryan White Program reimbursement for phenotype tests (not including virtual phenotype tests), as well as for the Highly Sensitive Tropism Assay if ViiV Healthcare is no longer covering the cost of the test. This is necessary to ensure use of the Ryan White Program as the payer of last resort.
- Reimbursements for injectables will be based on rates no higher than those found in the “2016 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, dated January 7, 2016 (payment limit column).”
- No multiplier will be applied to reimbursement rates for laboratory tests and related procedures, for non-evaluation and management procedures, for injectables, or for supplemental procedures.
- Medical procedures with an active Current Procedural Terminology (CPT) code that are excluded from the Medicare Fee Schedules may be provided on a supplementary schedule, upon request from the provider to the County for review. A flat rate along with a detailed description of the procedure and a cost justification for each supplemental procedure must be included in the provider’s submission request for review and approval by the County.
- Consumable medical supplies are limited and are only covered when needed for the administration of prescribed medications. Allowable consumable medical supplies are available only through the local Ryan White Program’s prescription drug service category. A list of allowable consumable medical supplies can be found as an attachment to the most current, local Ryan White Program Prescription Drug Formulary (i.e., Attachment B of this Formulary).

E. Rules for Reporting: Provider monthly reports for outpatient medical care must include the number of clients served, billing code for the medical procedures provided, number of units of service provided, and the corresponding reimbursement rate for each service provided. Providers must also develop a method to track and report client wait time (e.g., the time it takes for a client be

scheduled to see the appropriate medical provider after calling for an appointment; and upon arrival for the appointment, the time the client spends waiting to see the medical provider) and to make such reports available to OMB-GC staff or authorized persons upon request.

F. Additional Rule for Reimbursement: Requests for reimbursement of primary and/or specialty medical care services that are not submitted to the County within four (4) calendar months from the date of service may be denied.

G. Additional Rules for Documentation: Providers must ensure that medical records document services provided (e.g., medical visits, lab tests, diagnostic tests, etc.), the dates and frequency of services provided, as well as an indication that services were provided for the treatment of HIV infection, co-morbidity, or complication of HIV treatment. Clinician notes must be signed by the licensed provider of the service and maintained in the client chart or electronic medical record. Providers must maintain professional certifications and licensure documents of the medical staff providing services or ordering tests, and must make them available to OMB-GC staff or authorized persons upon request. Providers must ensure that chart notes are legible and appropriate to the course of treatment as mandated by Florida Administrative Code 64B8-9.003; and pursuant to Article VII, Section 7.1, of the provider's Professional Services Agreement with Miami-Dade County for Ryan White Program-funded services.

PLEASE NOTE: AS OMB-GC RECEIVES ADDITIONAL INFORMATION FROM FEDERAL FUNDERS AND/OR STATE LEGISLATIVE BODIES REGARDING IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) AND/OR HEALTH EXCHANGES, THESE GUIDELINES MAY BE REVISED.

OUTREACH SERVICES
(General HIV/AIDS Population & MAI)
(YEAR 26 Service Priority #9 for Part A and #4 for MAI)

I. Definition and Purposes of Outreach Services

Ryan White Program **Outreach Services**, a support service, target HIV positive (HIV+) clients in need of assistance accessing HIV care and treatment who are:

- Newly diagnosed with HIV/AIDS, not receiving medical care;
- HIV+, formerly in care, currently not receiving medical care (lost to care);
- HIV+, at risk of being lost to care; or
- HIV+, never in care.

Ryan White Program outreach services are directed to those known to be HIV+ and consist of activities to a) engage and enroll newly diagnosed clients into the system of care; b) assist HIV+ clients who are lost to care with re-entry into the care and treatment system; and c) assist HIV+ clients determined to be at risk of being lost to care with their retention and access to on-going medical care and treatment.

With implementation of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative and in collaboration with the Florida Department of Health Miami-Dade County's (FDOH M-DC) Early Intervention Program, newly diagnosed clients are the primary focus of service provision for outreach workers. Clients testing positive at state-licensed testing and counseling sites who sign an outreach consent form at their post-test counseling (Referral/Consent for Outreach Linkage to Care) will be contacted by Part A Outreach Workers for linkage to care either through medical case management or outpatient medical care. Outreach workers will enter all demographic and program-related information in the Ryan White Program's Service Delivery Information System (SDIS) for every client contacted, including those not eligible for Ryan White Program-funded medical care. Thirty (30) and sixty (60) day follow-ups from the date of initial appointment with a medical provider and/or medical case manager will be tracked in the SDIS.

Once an HIV+ lost-to-care or at risk of being lost-to-care client is located or an HIV+ client newly diagnosed and/or never in care is located, an SDIS outreach referral must be made to a medical case manager or medical provider of the client's choice. The outreach worker may assist the client in obtaining necessary documentation to receive services and may accompany the person to a point of entry into the system of care. Outreach workers must follow-up on each referral to ensure that the client is enrolled in medical case management and/or outpatient medical care. NOTE: Outreach services may be provided to clients with a rapid test preliminary positive result while a confirmatory HIV test result is pending, for the purpose of linking the client to care. **It is still necessary to obtain a**

confirmatory HIV test result; however within 30 calendar days, outreach services (e.g., connecting a newly diagnosed client to outpatient medical care or medical case management services) may be provided while a confirmatory HIV test result is pending. Time spent by outreach workers with clients who have a preliminary reactive test result and a pending confirmatory HIV test result is limited to a total of up to three (3) encounters within a 30 calendar day period. Effective May 1, 2016, the billing code “NIC” should be used to record such services to newly identified HIV+ clients only. The limit in the SDIS for this activity is a maximum of 3 encounters, to be completed within a 30 calendar day period.

Referrals to Ryan White Program Part A or MAI-funded outreach services from state-licensed counseling and testing sites may only be initiated if there is a valid outreach-specific consent (Referral/Consent for Outreach Linkage to Care) signed by the client and filed in the client’s chart.

- **NOTE: Outreach workers are required to pick up the Ryan White Program Referral/Consent for Outreach Linkage to Care within 24 hours of notice that a signed consent is waiting AND must make an initial attempt to contact the client within 48 hours of such notice.**

The Outreach Referral end date is thirty (30) calendar days from the initial referral date. At least one encounter must be provided within this 30-day period. Final outreach services must be provided within ninety (90) calendar days of the initial referral date. After ninety (90) calendar days the case should be closed, unless there is a well-documented reason for keeping the outreach case open.

Newly diagnosed clients who are referred to the Ryan White Part A or MAI Program through the Florida Department of Health (FDOH) linkage referral process who are not successfully contacted by a Ryan White Program Outreach Worker within thirty (30) calendar days of receiving a signed consent will be referred to FDOH M-DC Disease Intervention Specialists (DIS) for follow up.

New and lost to care clients who are served by Ryan White Part A/MAI Program outreach workers apart from the FDOH linkage process and are not successfully connected to care within ninety (90) calendar days should have their case closed unless there is a well-documented, reasonable justification for keeping the case open.

A. Newly Diagnosed HIV+ or HIV+ Never in Care

1. Linkage agreements form the basis of collaborative relationships between providers. Outreach providers must have formal referral and linkage agreements with one or more of the eleven (11) key points of entry to the system of care listed below for the purpose of receiving referrals for HIV+ clients identified at key points of entry.

- Florida Department of Health (FDOH) Miami-Dade County's (M-DC) Sexually Transmitted Disease (STD) clinics
- FDOH state-licensed HIV counseling and testing sites
- Hospitals/emergency room departments
- Hospital discharge clinics/departments
- Substance abuse treatment providers/programs
- Mental health clinics/programs
- Adult and juvenile detention centers
- Jail and/or correctional facilities, including, but not limited to, re-entry programs
- Homeless shelters
- Detoxification centers
- Federally Qualified Health Centers (FQHCs)

Linkage agreements must include the outreach worker's contact information, work schedule availability, geographic areas of the County covered, and a description of the outreach services offered. Clients referred from a key point of entry will be assisted to obtain necessary documentation for enrollment in the service system, will receive an SDIS referral to the primary medical care and/or medical case management service provider of their choice, may be accompanied to the initial appointment and must be followed-up to ensure that they are connected to care. Ryan White Program-funded outreach providers are required to cooperate with the FDOH M-DC's Early Intervention Counseling and Testing sites by supplying outreach/linkage to care workers at "Take Control Miami" events. Under the EIIHA mandate it is the responsibility of Ryan White Program-funded outreach/linkage to care workers to connect every new positive who has signed a Referral/Consent for Outreach Linkage to Care to medical case management and/or outpatient medical care; this includes connecting clients who are not eligible for Ryan White Program-funded services to care. The outreach worker must provide the client with provider information and track the client to ensure, through 30 and 60 day follow-ups from the date of initial appointment with a medical provider and/or medical case manager, that the client is actually linked to a medical case manager and/or a medical provider.

Time spent by outreach workers with clients who have a preliminary reactive test result and a pending confirmatory HIV test result is limited to a total of up to three (3) encounters within a 30 calendar day period. After which time a confirmatory HIV test result is required to continue serving the client.

B. Outreach to People Lost to Care or at Risk of Being Lost to Care

1. Outreach workers must work with service providers, including medical case managers, to locate people lost to medical care or medical case management and bring them back to care. The medical case manager, or pharmacy staff, after three (3) repeated attempts to contact the client by phone and/or mail without success, may refer the case through a Ryan White Program Certified Referral in the SDIS to an outreach worker. Jail linkage and prison re-entry coordinators may refer a client to an outreach worker if they have a signed document with permission for a Ryan White Program Part A or MAI outreach worker to contact them; such documents must be included with the OON referral and the supporting documentation being sent to the outreach provider. There must be clear documentation in the client chart at the referring agency, and recorded in the Ryan White Program Certified Referral, of at least three (3) repeated attempts by the medical case manager, pharmacy staff, or jail linkage/prison re-entry coordinator to contact the client and the reason why the case is being referred to an outreach worker. A Ryan White Program Certified Referral with last known contact information on the client indicating the reason for the outreach referral must be provided to the outreach worker and be maintained in both the medical case management and outreach client charts. In instances where it is clearly documented that a client has a history of non-compliance or clear documentation of extenuating circumstances, such as homelessness, repeated non-compliance with their treatment regimen, mental health issues, and/or a history of substance abuse, referrals to an outreach worker may be made after one or two attempts at contacting the client.
2. A Physician may immediately and directly request outreach assistance for a client who meets any of the conditions indicated directly below in Section B.3., or for similar circumstances (e.g., abnormal lab results, etc.). Such circumstances must be clearly documented in the client's chart and indicate that the assistance of an outreach worker was requested (i.e., the physician writes a prescription for the needed outreach and documents such in the client's medical record).
3. Examples of clients considered lost to care or at risk of being lost to care, which require a valid consent for outreach and three (3) documented attempts by the referring agency to reach the client, include:
 - Missing two (2) consecutive medical appointments;
 - Having no contact with a medical case manager for more than three months;
 - Checking out of residential substance abuse treatment;
 - Not "reporting" to residential substance abuse treatment;

- Missing the first medical care appointment after hospital discharge and/or referral to care;
- Missing picking up prescription medications or prescription referrals from a medical case manager or a pharmacy;
- Missing an appointment with the jail linkage or prison re-entry coordinator; and/or
- Missing a medical or social services appointment that the jail linkage or prison re-entry coordinator has scheduled.

NOTE: Clients lost to care or at risk of being lost to care may be contacted after one or two unsuccessful attempts at communication ONLY IF extenuating circumstances as outlined above are clearly documented in the individual client chart, and are recorded in the Ryan White Program Certified Referral.

Outreach providers must work with, and establish formal linkages with Ryan White Program medical providers and medical case management sites in order to receive outreach referrals from these providers who will identify clients who are lost to care or at risk of being lost to care. Outreach workers will then try to locate these clients and assist them in returning to ongoing medical care and treatment.

C. One Time Referrals

If in the course of outreach activities, outreach workers encounter a high-risk person with no documentation of HIV+ status, a referral should be made to an HIV testing site and/or appropriate prevention program in order to determine the client's HIV status. This one time referral may be counted and entered into the SDIS in the Outreach Registration screen. This is a **secondary** outreach function that will be monitored by OMB-GC and should not supersede the primary goals of connecting newly diagnosed (newly identified) clients to care, as well as locating and reconnecting to the service system those clients who have been lost to care or who are at risk of becoming lost to care. These secondary outreach services must be planned and delivered in coordination with local HIV prevention/education programs, including counseling and testing programs, in order to avoid duplication of effort.

D. Allowable Outreach Activities

1. Part A/MAI outreach workers may provide services to clients in the following situations to link or retain clients in HIV care: 1) for their agency's own clients; 2) upon receipt of a Ryan White Program Certified Referral for a particular client, for whom the referring agency has a valid informed outreach-specific consent signed by the client and filed in the client's chart; 3) upon receipt of a signed, completed Consent/Referral for Linkage to Care from state-licensed Counseling and Testing sites; 4) a prescription from a

physician; or 4) by a letter or referral from a jail linkage or prison re-entry coordinator as indicated in Section B.1. above.

2. Outreach workers may engage in the following activities, if the activity is properly documented and filed in the client's chart at the referring agency and at the receiving agency where applicable:

- Obtain from the client all required consents for the outreach worker to access client-related information in the Ryan White Program's SDIS;
- Conduct brief intakes for new clients and enter data into the SDIS outreach registration screen;
- Upon receipt of a proper referral, review data in the SDIS for existing clients who are lost to care or are at risk of falling out of care;
- Complete assessments and document new clients' barriers to accessing care and lost-to-care clients' reasons for falling out of care;
- Contact the service provider of the client's choice to coordinate appointments and obtain required documentation for services;
- Accompany newly diagnosed, lost to care, or otherwise unconnected HIV+ clients to the initial physician appointment and/or medical case management appointment for the purpose of reconnecting them to care or enrolling them in service;
- Accompany clients, as necessary, for the purpose of assisting them to obtain necessary documents for entry into the service system;
- Conduct home visits to meet with a client for the purpose of connecting them to care;
 - NOTE: if a Part A/MAI-funded outreach service provider has an established agency policy not to send staff to conduct home visits, and it is determined that a home visit is necessary for successful linkage, the client's case should be transitioned to a Part A/MAI-funded outreach provider that is able to conduct home visits;
- Maintain tracking and contact logs for new to care and lost to care clients;
- As a safety precaution, Ryan White Program outreach workers who must locate clients in high-risk areas or very rough neighborhoods may go out in two-person teams. In this scenario, both outreach workers should document the activity in the client chart or outreach log, making note that they went to a high risk area, with one of the outreach workers clearly stating that they went along as a safety back-up and should use the OSFT safety back-up code to record the service. Both outreach workers may

reflect the time they spent on the encounter and have their agency or respective agencies report for the time and be reimbursed accordingly. However, in the SDIS the encounter should only be counted/recorded (i.e., OFFE, OTEL, ORFL, etc.) by the main outreach worker/agency that received the referral;

- Provide education on available care and treatment options and services available to HIV+ individuals with the goal of directly empowering and enabling the client to access existing HIV/AIDS service programs, including Counseling & Testing sites;
- Provide out-stationed linkage and coordination to care services at key points of entry, including but not limited to counseling and testing facilities and other facilities with a high percentage of HIV+ clients as identified by the counseling and testing facility and verified by the Ryan White Part A Program;
- Coordinate and participate in planned outreach/testing events such as “Take Control Miami” in cooperation with the FDOH M-DC;
- Conduct 30 and 60 day follow-ups from the date of initial appointment with a medical provider or medical case manager to ensure the client (regardless of whether the client is receiving services through the Ryan White Program) remains connected to care.

2. **Inappropriate Outreach Activities.** Funds awarded under Part A and MAI of the Ryan White HIV/AIDS Treatment Extension Act of 2009 may not be used for outreach programs that exclusively promote HIV education and prevention programs; condom distribution, and/or case finding that have as their main purpose broad-based HIV prevention education. Additionally, broad-scope awareness activities about HIV services that target the general public (i.e., poster campaigns for display on public transit, TV or radio public service announcements, health fairs directed at the general public, etc.) will not be funded.

Part A/MAI outreach services do not include direct HIV counseling and testing or HIV prevention education. However, Part A/MAI outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort.

Outreach Workers may not conduct random searches in the SDIS for clients who are not enrolled at the Outreach Workers’ assigned agency, or for clients for whom they do not have a Ryan White Program Certified Referral. Searches conducted in the SDIS to identify clients lost to care must be initiated by the medical case manager or medical staff of the referring agency.

Ryan White Program-funded outreach activities are not to be used for general recruitment of clients to the outreach worker’s agency.

3. **Documentation of Outreach Activity.** All outreach workers must maintain documentation which includes the following:

- Name of outreach worker;
- Name, signature, and consent of client;
- Client's date of birth;
- Client's gender;
- Client's race and ethnicity;
- Client's address or follow-up information;
- Date of diagnosis and site of diagnosis;
- Date of the encounter;
- Type of encounter (i.e., telephone, face-to-face, collateral, travel, referral, or coordination of care);
- Description of the encounter with a client and/or work done on behalf of the client;
- Time spent on the encounter in minutes;
- Total units documented;
- For newly diagnosed clients, a Referral/Consent for Linkage to Care;
- For clients lost to care, a Ryan White Program signed outreach consent to be contacted (found at the top of the County's Notice of Privacy Practices form);
- Site where client was identified (i.e., last known contact information, a specific geographic region, and/or key point of entry into the system of care in Miami-Dade County);
- One time referral to a testing site for a high-risk client without documentation of HIV status;
- Document "initial contact" and all "follow-up" contacts;
- Maintain call logs and tracking logs for new-to-care and lost-to-care clients;
- If lost to care or identified as at risk of being lost to care, a copy of the initiating agency's referral to outreach;
- An individualized assessment of the client's barriers to care or reasons for falling out of care;
- Documentation that explanation of service system and choice of provider agency were provided;
- A copy of an SDIS referral or documented attempt to make a referral by the outreach worker to a medical case management agency and/or medical provider of the client's choice;
- Documentation of 30 and 60-day (calendar days) follow-up on referrals to ensure that the client is enrolled in medical care and treatment;
- Final disposition of the client must be documented in SDIS, the client's chart or service log indicating whether or not the client was

connected to care (i.e., referral was made; client was taken to a medical provider or medical case manager) or if the case was closed with a statement as to why it was closed;

- Contact with the referring agency to communicate the client’s final disposition.

II. Outreach Worker Incentives, Program Operation Requirements, and Staff Training Requirements

As incentives for productivity, providers are encouraged to provide outreach workers with educational training opportunities. The Ryan White Program also has educational and training requirements for outreach workers to improve productivity.

A. Program Operation Requirements:

1. **Staff Training.** Outreach workers must possess at least a High School diploma or GED. All staff providing outreach services must complete the FDOH’s “HIV/AIDS in the News” (available through Behavioral Science Research Corporation (BSR)). Outreach workers must attend periodic training provided by the Ryan White Program’s Quality Management and Training Program provided by BSR.

Outreach providers must ensure that outreach workers are knowledgeable about resources and providers of medical care, substance abuse treatment, medical case management, and other core and support services. At a minimum, the outreach provider should have reference material on hand which provides information on services offered, intake requirements, hours of operation, and contact personnel information. Outreach workers must also have on hand Ryan White Program consent forms available for signature by clients lost to care or at risk of being lost to care.

2. **Hours.** Outreach services must be offered during non-traditional business hours, 10 hours at a minimum per week, per agency. Traditional business hours are defined as 9:00 a.m. to 5:00 p.m., Monday through Friday. Each Ryan White Program-funded outreach provider must have written procedures in place to address on-call coverage to reach an outreach worker after traditional business hours. The written procedures should include steps for contacting an on-call medical provider and/or medical case manager, where immediate intervention is necessary.

3. **Cultural Sensitivity.** Providers are encouraged to be creative in developing outreach programs that are culturally sensitive and that meet the specific needs of the identified target sub-populations (i.e., substance abusers, illiterate persons, hard of hearing, sex workers, etc.). It is desirable that outreach workers reflect the community in which they are working and/or are targeting.
4. **Documentation of Units of Service.** Providers are required to document in the client's chart each unit (15-minute encounter) of outreach service performed (including the time spent) as a face-to-face encounter, telephone contact, collateral encounter on behalf of the client, coordination of care, travel, or referral activity on behalf of a client.

Outreach providers may record collateral contacts, using the billing code OCOL. Use this code to record activities related to **coordination of care** for clients, including communication with other care providers, such as telephone contacts or other electronic methods of communication (e.g., email or fax). This code also includes other coordination of care activities that are conducted for or on behalf of the client, such as **referral activities** that are not face-to-face with the client and obtaining completed documents for the client from another (outside) care provider. This code should NOT be used for internal agency activities that are unrelated to the coordination of care for clients with outside providers. Examples of inappropriate use of this code include pulling a chart to copy documents for a client's personal use or filing for chart maintenance.

Outreach providers may record documentation activities, using the billing code ODOC. Use this code to record activities related to documenting any encounter in the SDIS, such as the client's care plan, progress note, face-to-face encounter, telephone contact, etc. This service code also includes time spent filing or organizing the client chart or pulling the chart to make copies that are unrelated to coordination of care for the client.

Ryan White Part A/MAI Program-funded outreach workers should use the TCM billing code to record outreach activities conducted at authorized "Take Control Miami" events.

Ryan White Part A/MAI Program-funded outreach workers may also record and bill for time spent attending authorized Ryan White Program trainings (TRN), such as monthly case management and case management supervisor trainings, outreach worker trainings, Service Delivery Information System trainings, and quarterly Ryan

White Program Provider Forums. (NOTE: The TRN code may not be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code cannot be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, on-site BSR technical assistance visits; appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, or other employer-required training.) Travel time is not included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code.

Outreach Supervisors may use the code OREV to record activities associated with chart review processes to ensure that outreach staff is in compliance with this service definition, and with the Ryan White Program System-wide Standards of Care. Outreach Supervisors may also use the code OCON to record activities associated with consulting with outreach staff on Ryan White Program-related client, supervisory, or quality management issues. Supervisors are **REQUIRED** to report a minimum of 10 hours each quarter for both the OREV and OCON codes (total of 20 hours per quarter). (IMPORTANT: See subsection II.D. below regarding “Applicability to Local Ryan White Program Requirements” for staff supervising Ryan White Program-funded outreach workers.)

Ryan White Part A/MAI Program-funded outreach workers who as a safety precaution accompany a Ryan White Program outreach worker when locating clients in high-risk areas or very rough neighborhoods, as indicated in Section I.D.1 above, should use the OSFT safety back-up code to record the service. In this scenario, if applicable, both outreach workers should document the activity in the client chart or outreach log, making note that they went to a high risk area, with one of the outreach workers clearly stating that they went along as a safety back-up. Both outreach workers may reflect the time they spent on the encounter and have their agency or respective agencies bill for the time and be reimbursed accordingly. However, in the SDIS the other outreach billing code (i.e., OFFE, OTEL, ORFL, etc.) should only be counted or recorded by the main outreach worker/agency that received the referral;

Effective May 1, 2016, use the NIC code to record limited services to newly identified clients whose preliminary test is positive and the confirmatory test result is pending. Use of this code is limited to three (3) encounters within a thirty (30) calendar day period.

5. **Connection to Care.** Providers are expected to demonstrate through documentation on file at the provider agency that at least fifty percent (50%) of people contacted and billed for are actually returned to primary medical care and/or medical case management services or that a case was closed, and at least fifty percent (50%) of the people contacted and billed for are new to primary medical care and/or medical case management services, on a quarterly basis. Connections to care will also be monitored by the County on a quarterly basis through the SDIS and/or analysis of outreach data conducted by BSR, as a Quality Management Program activity.

B. Rules for Reimbursement: Providers will be reimbursed on the basis of a line-item budget for Part A and MAI-funded outreach services. Ryan White Program outreach services will be paid on the basis of full-time equivalent (FTE) employees providing direct services as outlined in this service definition, as well as on the basis of other allowable direct and administrative costs. Reimbursement of salaries will be based on the approved budget and productivity as recorded by hours spent doing allowable outreach activities, people contacted, their risk factors, and the number of HIV+ people connected to care. All administrative and/or indirect expenses allocated to this service category (other than those associated with the delivery of outreach services to clients) are capped at 10% of the total award for the service category.

C. Additional Rules for Reporting: Monthly activity reporting for this service will be on the basis of an outreach contact in comparison with the amount of time and effort billed to the program for each outreach worker.

Reimbursement requests will be continuously evaluated on the basis of productivity; in particular, people contacted and connected to primary medical care or medical case management services. A sufficient level of outreach services must be provided and a corresponding bill generated through the SDIS on a monthly basis in order for reimbursement to be approved by the County. The County maintains the right to assess the sufficiency of the services provided before reimbursement for services is made.

D. Applicability to Local Ryan White Program Requirements: If a staff person has a Ryan White Program outreach service caseload, even one client, they will be required to adhere to the local Ryan White Program Service Delivery Guidelines, System-wide Standards of Care, and Quality Management Program activities. This requirement is applicable whether or not the outreach staff person appears on the program's line item budget and regardless of the percentage of time and effort spent performing Ryan White Program outreach activities. Similarly, if they supervise any Ryan

White Program outreach staff, whether or not they are on the budget for such, they also must follow the requirements in the local Ryan White Program Service Delivery Guidelines, System-wide Standards of Care, and Quality Management Program activities.

PRESCRIPTION DRUGS (General HIV/AIDS Population & MAI)
(YEAR 26 Service Priority #3 for Part A and MAI)

- A. The purpose of the Local Pharmaceutical Assistance Program (LPAP) (i.e., prescription drug services), in accordance with federal Ryan White Program guidelines, is “to provide therapeutics to treat HIV/AIDS or to prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals, including measures for the prevention and treatment of opportunistic infections.” LPAPs must be compliant with the Ryan White HIV/AIDS Program’s requirement of payer of last resort. **LPAP (Prescription Drugs)** is a core medical service.

This service includes the provision of medications and related supplies prescribed or ordered by a physician or other licensed medical practitioner to prolong life, improve health, or prevent deterioration of health for HIV+ persons who are ineligible for Medicaid, Medicare Part D, ADAP, or other public sector funding, or have private insurance with limited or no prescription drug coverage.

IMPORTANT NOTE: Services are restricted to outpatient services only. Inpatient and emergency room prescription drug services are not covered. Vaccines provided during a medical office visit are no longer found in the local Ryan White Program Prescription Drug Formulary, but may be available under outpatient medical care services. Prescription drug co-payment assistance is not provided for clients with prescription drug discount cards. LPAP services may not be provided on an emergency basis (defined as a single occurrence of short duration).

1. **Medications Provided:** This service pays for injectable and non-injectable prescription drugs, pediatric formulations, and non-prescription nutritional supplements, appetite stimulants, and/or related consumable medical supplies for the administration of medications. Medications are provided in accordance with the most recent release of the Ryan White Program Prescription Drug Formulary and also include assistance for the acquisition of non-Medicaid, Medicare Part D, or ADAP reimbursable drugs, as well as the purchase of consumable medical supplies that are required to administer prescribed medications. The Ryan White Program Prescription Drug Formulary is subject to change due to guidance from HRSA, the federal granting agency, and/or the Miami-Dade HIV/AIDS Partnership’s Medical Care Subcommittee.
2. **Client Education and Adherence:**
 - Providers are expected to educate clients on the importance of adhering to their medication regimen with the objectives of reducing the risk of developing and spreading a resistant virus, and to ensure a healthy life for the client.

- Providers are expected to offer basic education to clients on various treatment options, including information about state of the art combination drug therapies.
- Clients must be encouraged to take medications as prescribed, as well as to follow the recommendations made by physicians, nutritionists, and pharmacists regarding medication management.

3. Coordination of Care:

- Providers must maintain appropriate contact with other caregivers (i.e., the client's medical case manager, physician, nutritionist, counselor, etc.) and with the client in order to monitor that the client adheres to their medication regimen; and ensures that the client receives coordinated, interdisciplinary support for adherence, and assistance in overcoming barriers to meeting treatment objectives.
- Providers will be expected to immediately inform medical case managers when clients are not adhering to their medication regimen (i.e., the client misses prescription refills, misses physician visits, or is having other difficulties with treatment adherence).
- Providers are expected to ensure immediate follow-up with clients who miss their prescription refills, physician visits, and/or who experience difficulties with treatment adherence.

B. Program Operation Requirements:

- Providers are encouraged to provide county-wide delivery. However, Ryan White Program funds may not be used to pay for the delivery of medications or consumable medical supplies unless one of the following conditions is met by the client, is documented by the client's physician, and said documentation is maintained in the client's chart:
 - (1) The client is permanently disabled (condition is documented once);
 - (2) The client has been examined by a physician and found to be suffering from an illness that significantly limits his/her capacity to travel [condition is valid for the period indicated by the physician or for sixty (60) calendar days from the date of certification].

Note: Medical case managers requesting home delivery must have documentation on file that meets one of the conditions listed above.

- Providers must specify provisions for home delivery of medications and related supplies and equipment for eligible Ryan White Program clients who require this service.
- Provision of this service may not be limited to an agency's own clients unless Public Health Service (PHS) 340B covered entity status requires this restriction. However:
 - Clients may only go to, or be referred to, the pharmacy in which their primary care physician or prescribing practitioner is located or affiliated with. This is due to PHS 340B Pharmacy pricing limitations, and HRSA's requirements that the Ryan White Part A/MAI Program use PHS 340B pricing wherever possible.
 - If the provider is a PHS 340B covered entity and the client is enrolled in the state ADAP Program, that client is eligible for PHS 340B pricing for prescriptions not covered by the ADAP formulary regardless of whether or not the client is the agency's own client.
- Pharmacy providers are directed to use the most cost-effective product, either brand name or generic name, whichever is less expensive at the time of dispensing. An annual, signed assurance is required from the service provider regarding this directive.
- The service provider must be linked to an existing medical case management system through agreements with multiple medical case management providers. Providers are contractually required to enter into formal referral agreements that detail responsibilities of both parties and penalties for not complying with the referral agreement.

A Ryan White Program Certified Referral Form for Prescription Drug Services must be completed by a medical case manager (or a General Out-of-Network Referral from a non-Part A or non-MAI case manager) and must be attached to the original prescription presented by the client or a designee. The Certified Referral Form must include a client ID number traceable to the case management agency initiating the referral and a client CIS number assigned by the Ryan White Program Service Delivery Information System, if applicable. The referring case management agency is responsible for collecting and reporting all required client eligibility documentation, release of information, consent for services, and demographic information. The Ryan White Program's referring medical case management agency maintains this information on-site. The non-Part A or non-MAI referring case management agency must include this documentation with the OON referral form. Prescription referrals require the full name of the client's prescribing physician or practitioner and/or the primary care physician.

Referrals for Ryan White Program-funded prescription drug services have a maximum of five (5) refills plus the original fill, regardless of recertification dates. However, if during the recertification process it is determined that the client is no longer eligible for Ryan White Program services or the client has missed their recertification deadline, the medical case manager must immediately notify the pharmacy to cancel the remaining refills.

C. Rules for Reimbursement: Dependent on the type of pharmacy provider, please adhere to the following reimbursement structures.

- Where applicable, providers will be reimbursed for prescription drugs based on the PHS 340B price of the prescription provided to the Ryan White client, plus a flat rate dispensing fee. Total costs should include the cost of home delivery, as allowable, and other direct costs associated with the provision of this service. Providers must stipulate the flat rate dispensing fee that will be added to the PHS price. (For example, if the PHS price of a prescription for Atripla is \$185.00, and the provider's proposed flat rate dispensing fee is \$11.00, then the total reimbursement amount is equal to \$196.00.) An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form.
- Where applicable, providers will be reimbursed for prescription drugs based on the Average Wholesale Price (AWP) of the prescription provided to the Ryan White client, minus a per-prescription discount rate. Total costs should include the cost of home delivery, as allowable. Providers must stipulate the discount rate that they will be subtracting from the AWP, which may not be less than 10%. Please note that providers may utilize a discount rate higher than 10% (i.e., AWP - 14%). (For example, if the AWP of a prescription for Atripla is \$1,756.00, and the provider's proposed discount rate is 10%, then the total reimbursement rate is equal to \$1,580.40.) An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form.
- Reimbursement for consumable medical supplies is limited and must be related to the administration of medications (e.g., for insulin injection in diabetics, etc.). Approved consumable medical supplies are found in Attachment B of the most current, local Ryan White Program Prescription Drug Formulary.
- No multiplier will be applied to Medicare or Medicaid rates for consumable medical supplies.

D. Additional Rules for Reporting and Documentation: Providers must document client eligibility for this service and report monthly activity in terms of the individual drugs dispensed (utilizing federally assigned drug codes to be provided by the County), the number of prescriptions filled for each drug, the number of pills or units dispensed, the amount of Ryan White Program funds spent dispensing each drug, and the unduplicated number of clients that received each drug limited to those medications listed in the most recent release of the Ryan White Program Prescription Drug Formulary.

Provider monthly reports for consumable medical supplies must include the number of clients served, medical supply distributions with HCPCS codes as appropriate per client, and dollar amounts per client.

E. Ryan White Program Prescription Drug Formulary: Ryan White funds may only be used to purchase or provide vitamins, nutritional supplements, appetite stimulants, and/or other prescription medications to HIV/AIDS clients as follows:

- Prescribed medications that are included in the most recent release of the Ryan White Program Prescription Drug Formulary. This formulary is subject to periodic revision; and
- Medications, nutritional supplements, appetite stimulants, or vitamins that have been prescribed for the client by his/her physician. NOTE: Prescriptions for nutritional supplements and vitamins may be written for a 90-day (calendar days) supply.

F. Letters of Medical Necessity: The following medications and test require a completed Ryan White Letter of Medical Necessity or Prior Authorization Form (See Section V of this Service Delivery Guidelines book, as may be amended):

Medications:

- **Aptivus** (Tipranavir)
- **Fuzeon** (Enfuvirtide)
- **Neupogen** (Filgrastim)
- **Nutritional Supplements** (for Adults)
- **Procrit or Epogen** (Epoetin Alpha)
- **Roxicodone** (Oxycodone) **and Percocet** (Oxycodone/APAP)
- **Sporanox** (Itraconazole)
- **Testosterone** (Cypionate and Enanthate injection only)

Test:

- **Highly Sensitive Tropism Assay** [required to prescribe Selzentry (Maraviroc)] – (The Ryan White Program LOMN for the Highly Sensitive Tropism Assay is only required when ViiV Healthcare or any other funding source does not pay for the test.)

Please Note: Medical case managers must work with clients to explore in a diligent and timely manner all health insurance options and evaluate the client's best option to ensure that health insurance premiums, deductibles and prescription drug co-payments are reasonable and covered by the appropriate payer source. For Medicare Part D recipients, any client whose gross household income falls below 150% of the 2016 Federal Poverty Level (FPL) must be enrolled in the Low Income Subsidy (LIS) Program. In addition, for Medicare Part D recipients, any client whose gross household income falls between 135% and 150% of the FPL must be enrolled in ADAP for assistance with prescription drug expenses. For Medicare Part D recipients, any client whose gross household income falls above 150% of the FPL or does not qualify for the LIS and who falls into the "donut hole," must be referred to the ADAP Program.

ADDITIONALLY PLEASE NOTE: AS OMB-GC RECEIVES ADDITIONAL INFORMATION FROM FEDERAL FUNDERS AND/OR STATE LEGISLATIVE BODIES REGARDING IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) AND/OR HEALTH EXCHANGES, THESE GUIDELINES MAY BE REVISED.

**SUBSTANCE ABUSE COUNSELING -
OUTPATIENT COUNSELING AND RESIDENTIAL TREATMENT
(General HIV/AIDS Population & MAI for Residential Treatment)
(YEAR 26 Service Priorities #7 for outpatient;
and #10 for Part A or #5 for MAI residential)**

Two types of **Substance Abuse Counseling/Treatment** programs are included under this service category, **Outpatient and Residential**. **Outpatient substance abuse counseling** is a core medical service. **Residential substance abuse treatment** is a support service. Services must be provided to HIV+ clients in state-licensed treatment facilities.

Both **Outpatient Counseling and Residential Substance Abuse Treatment** programs shall comply with the following requirements:

- A. Program Operation Requirements:** Providers are encouraged to provide services that are highly accessible to target populations.

Providers are also encouraged to demonstrate linkages with other service providers relevant to the needs of HIV+ persons in substance abuse treatment programs. Providers should especially demonstrate linkages with other services relevant to the needs of people in substance abuse treatment programs including housing and shelter programs.

Service must be provided in settings that foster the client's sense of self-control, dignity, responsibility for his/her own actions, relief of anxiety, and mutual aid.

Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV+ client is also being served. Providers are encouraged to offer program services to families without separating the family unit. A family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.A. of this service definition on the following page for details). *Note: For the purpose of this service, family members are defined as those individuals living in the same household as the client.*

Individual treatment plans must be documented in the client's chart and linked to the provision of primary medical care.

Providers must ensure that clients adhere to their treatment plan, including prescription drug regimens.

Providers of substance abuse treatment must offer flexible schedules that accommodate nutritional needs in order to facilitate client compliance with medication regimens.

Providers are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate.

Residential substance abuse treatment is not a pre-requisite to access outpatient substance abuse counseling. However, clients graduating from residential substance abuse counseling are encouraged to transition to outpatient substance abuse treatment/counseling services.

I. Substance Abuse Counseling - Outpatient Counseling (Priority #7)

Substance Abuse Counseling – Outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel as indicated below. This program provides regular, ongoing substance abuse monitoring and counseling on an individual and/or group basis in a state-licensed outpatient setting. Outpatient substance abuse counseling services should be limited to the pre-treatment/recovery readiness programs; harm reduction; mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; conflict resolution; anger management; relapse prevention; drug-free treatment and counseling; and treatment for alcohol addiction and other drug addictions. All clients receiving this service must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of substance use disorder.

Limited acupuncture services may be provided with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever required by State law.

Providers of this service must specify the maximum number of clients expected to be enrolled in a group counseling session. The minimum amount of group participants is three (3) Ryan White Program clients per group and should be no higher than fifteen (15) persons per group. The ratio of support group participants to counselors should be no lower than 3:1 and no higher than 15:1. One unit is equal to one half-hour counseling session. **Substance Abuse Counseling levels are specific to the education level of the provider of the service, as indicated below, and are not interchangeable:**

- **Substance Abuse Counseling (Level I) - Professional Substance Abuse Counseling.** This Level I service includes *general and intensive* substance abuse therapy and counseling (individual, family, and group) provided by trained mental health or certified addiction professionals. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas

appropriate for individual and group socio-emotional support. Direct service providers for Level I must possess at least *postgraduate degrees* (PhD or Master's degree) in the appropriate counseling-related field, and preferably be licensed as a *certified addiction professional* (CAP), Licensed Clinical Psychologist, LCSW, LMHC, or LMFT to provide such services.

- **Substance Abuse Counseling (Level II) - Counseling and Support Services.** This Level II service includes supportive and crisis substance abuse counseling by trained and supervised counselors (who may possess Bachelor's degrees or have related experience, and may not be licensed), peers, and facilitators. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Non-certified personnel providing this Level II service will be supervised by professionals with appropriate Level I substance abuse counseling credentials.
- B. Additional Service Delivery Standards:** Providers of these services will also be required to adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS. (Please refer to Section III of this book for details.)
- C. Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half hour counseling session not to exceed \$30.00 per unit for Level I individual counseling; \$34.00 per unit for Level I group counseling; \$27.00 per unit for Level II individual counseling; and \$30.00 per unit for Level II group counseling. Reimbursement for individual sessions is calculated for each client and/or family member(s) receiving the therapy, whereas, reimbursement for group sessions is calculated for the counselor that provided the group therapy. Documentation activities are included in the substance abuse counseling unit of service, and are not to be billed as a separate encounter. Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV+ client is also being served. The HIV+ client must be currently receiving such services; and preferably, but not necessarily, the family member may be served on the same day as the client.
- D. Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a *one half-hour counseling session* provided to the client and the number of unduplicated clients served. Providers must also report, on a monthly basis, the number of group counseling units provided by each counselor.

- E. Linkage/Referrals:** Providers of outpatient substance abuse treatment must document the client's progress through the treatment program, maintain linkages with one or more residential facilities, appropriate community services, including 12-step programs, and be able to refer or place clients in a residential program, in collaboration with the client, his/her medical case manager, and primary care physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving medical case management services; if not, the provider must seek enrollment of the client in a medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the medical case management provider must be established in order to ensure coordination of services while the client remains in treatment. *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.
- F. Additional Rules for Documentation:** Providers must submit an assurance to OMB-GC that outpatient substance abuse services are only provided in an outpatient setting. Providers must maintain professional certifications and licensure documents as required by the State of Florida for staff providing residential substance abuse treatment services to Ryan White Program clients, and must make these documents available to OMB-GC staff or authorized persons upon request. Providers must also submit to OMB-GC a copy of the staffing structure showing supervision by a physician or other qualified personnel. Providers must also maintain client charts that include treatment plans with all required elements, including but not limited to measurable goals and timelines for completion. Documentation in the client chart must also clearly indicate that services were provided as allowable under the Ryan White Program service definition, and include the quantity, frequency and modality of treatment services, the date treatment begins and ends, regular monitoring and assessment of client progress, and a signature of the individual providing the service or the supervisor as applicable. If acupuncture services were provided, a copy of the written referral from the primary health care provider must be in the client chart.

II. Substance Abuse Counseling – Residential Treatment (Priority #10 for Part A or Priority #5 for MAI)

This program offers substance abuse treatment, including alcohol addiction and/or addiction to legal and illegal drugs, and counseling to HIV+ clients in state-licensed treatment facilities on a short-term basis. Residential substance abuse treatment provides room and board, substance abuse treatment, including specific HIV counseling, in a secure, drug-free, state-licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Ryan White Program funds may not be used for hospital inpatient detoxification. All

clients must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of substance use disorder. Services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State of Florida.

If the client is participating in a residential treatment program, the client's family member may visit the facility and participate in the counseling sessions, but the family member may not physically live in residential treatment with the client during the treatment process. As a reminder, a family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.A. of this service definition on the following page for details).

Residential treatment programs shall comply with the following requirements:

- B. Rules for Reimbursement:** The unit of service for reimbursement of substance abuse counseling - residential treatment is a *client-day* of care up to a maximum amount of \$150.00 per day. The maximum rate is subject to approval by the County's Office of Management and Budget-Grants Coordination (OMB-GC). **Under no circumstance may clients be enrolled in any Ryan White Program-funded residential substance abuse treatment program for longer than 120 days within a twelve-month period. Twelve months begins on the very first day of a client's residential treatment, and restarts every 12 months based on that original start date for Ryan White Program-funded residential substance abuse treatment services. NO EXCEPTIONS. The length of stay for existing clients will be closely monitored by the County's OMB-GC/Ryan White Program.**

Residential substance abuse treatment providers are strongly encouraged to do a ".RSA" search in the Service Delivery Information System (SDIS) in order to determine how many days of residential treatment service have already been billed for the client, and how many days are remaining in the client's 120-day/12-month period. In addition, providers should call or email the client's previous substance abuse treatment provider, if applicable, to inquire if any services are pending to be entered or compiled in the SDIS. This will affect the actual number of available days versus those that appear in the SDIS.

- C. Additional Rules for Reporting:** Monthly activity reporting for residential substance abuse treatment is per *client-day* of care and number of unduplicated clients served. Providers will indicate in the SDIS the client's disposition after residential substance abuse treatment services has ended (e.g., treatment completed, client referred to outpatient substance abuse counseling, client withdrew from treatment, etc.).

- D. Linkage/Referrals:** Providers of residential substance abuse treatment must document the client's progress through the treatment program, maintain linkages with one or more outpatient facilities and appropriate community services, including 12-step programs, and be able to refer or place clients in an outpatient program, in collaboration with the client, his/her medical case manager, and the primary care physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving medical case management services; if not, the provider must seek enrollment of the client in a medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the medical case management provider must be established in order to ensure coordination of services while the client remains in treatment. **A client's Ryan White Program-funded medical case manager will receive an automated "pop-up" notification through the Service Delivery Information System upon the client's discontinuance or release from, completion of, and/or relapse in residential substance abuse treatment.** *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.
- E. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation including all required consent forms and Notice of Privacy Practices) is required for this service. Clients receiving Ryan White Program Part A or MAI-funded residential substance abuse counseling/treatment must be documented as having gross household incomes below 300% of the 2016 Federal Poverty Level (FPL).
- F. Additional Rules for Documentation:** Providers must also maintain professional certifications and licensure documents as required by the State of Florida for staff providing residential substance abuse treatment services to Ryan White Program clients, and must make these documents available to OMB-GC staff or authorized persons upon request. Providers must submit to OMB-GC a copy of the staffing structure showing supervision by a physician or other qualified personnel, and an assurance that all services are provided in a short-term residential setting. Providers must also maintain client charts that include individual treatment plans with all required elements and document that services were provided as allowable under the Ryan White Program service definition, the quantity, frequency and modality of treatment services, the date treatment begins and ends, regular monitoring and assessment of client progress, and a signature of the individual providing the service or the supervisor as applicable. If acupuncture services were provided, a copy of the written referral from the primary health care provider must be in the client chart.

TRANSPORTATION VOUCHERS
(YEAR 26 Service Priority #11)

Transportation Vouchers is a support service that provides specially-designated, discounted Miami-Dade Transit Agency (MDTA) Metro (transportation) EASY Tickets to eligible HIV+ clients attending medical and/or social service appointments. This includes monthly tickets.

Providers of EASY Tickets must demonstrate coordination with Miami-Dade County transportation agencies and services, Medicaid Special Transportation, Miami-Dade Special Transportation Services (STS), and other existing transportation programs to avoid duplication of services. In addition, providers of transportation tickets are encouraged to apply annually to the Miami-Dade Transit Transportation Disadvantaged Program in order to obtain assistance for clients eligible under that program. As a reminder, the Ryan White Program is to be used as the payer of last resort.

- A. Program Operation Requirements:** Discounted EASY Tickets cost \$56.25 per month for unlimited trips during the calendar month; and may be subject to change. These specially-designated EASY Tickets will not be usable in other months and are not “re-loadable.” The amount for EASY Tickets should be consistent throughout the duration of the contract period and must take into consideration the total budget request, agency capacity, client eligibility, and demand for this service. For any given month, once an allotment of tickets has been exhausted, providers may not distribute additional tickets for that month.

Monthly transportation tickets must be distributed in a timely manner (no later than the 5th day of the month) in order to maximize ticket usage. If the 5th day of the month falls on a weekend, providers may distribute vouchers and bill to the Ryan White Program through the following Monday (e.g., if May 5th is a Sunday, providers can distribute transportation vouchers through May 6th, Monday). Unused transportation tickets should be returned to the MDTA for credit. Agencies must follow MDTA’s procedures for ticket returns. Unused or undistributed discounted EASY tickets cannot be charged to the Ryan White Program.

Providers must inform clients that this type of assistance is **not** an entitlement. Therefore, the level of assistance provided to individual clients is based on relative need. Clients must also be informed that the availability of transportation tickets is contingent upon funding availability and, therefore, the continuance of this type of assistance is not guaranteed.

Providers must document criteria, policies, and procedures utilized to determine transportation EASY Tickets allotments for clients that must take into account not only minimum requirements, but also consideration for those clients who

demonstrate the greatest need for these services. This documentation must be provided to the Miami-Dade County Office of Management and Budget-Grants Coordination upon request.

- Documentation of multiple [at least three (3)] monthly medical and/or social service appointments must be submitted by the client to his/her medical case manager before the client can receive transportation assistance. If allowable appointments are appropriately documented in the client chart for each month of service, the Ryan White Program will not restrict the total number of months in which the client can receive transportation services during the Fiscal Year. Service providers will monitor the consistency of client attendance at these monthly medical and/or social service appointments to ensure compliance with the requirement for use of transportation vouchers under this program. If clients are non-adherent to appointments this will be documented and service providers have the discretion, on a case-by-case basis, to not issue a voucher to continually non-compliant clients. “Non-compliant” is defined herein as two missed appointments in two consecutive months (e.g., two months in which two or more appointments have been missed each month without acceptable excuse or cancellation for cause by client would be considered non-compliant). Miami-Dade County Office of Management and Budget-Grants Coordination staff will also monitor compliance with this restriction.

B. Rules for Reimbursement: Providers will be reimbursed based on properly documented service utilization reports from the Service Delivery Information System (SDIS), indicating the date of EASY Ticket distribution, client CIS number, and dollar amount including dispensing charge. Dispensing charges, not to exceed 15%, will be reimbursed after services have been provided, client utilization and disbursement information is submitted to the County, and vendor payment has been documented. This service is subject to audit by the Office of Management and Budget-Grants Coordination. EASY Ticket orders, invoices, and payments, as well as monthly distribution logs signed by the client, will be reviewed.

C. Additional Rules for Reporting: Providers must report monthly activity according to the dollar amount of the tickets issued, the number of tickets, and the unduplicated number of clients served.

D. Special Client Eligibility Criteria: A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated every six (6) months. Clients receiving Ryan White Program Part A-funded transportation assistance must be documented as having gross household incomes below 150% of the 2016 Federal Poverty Level (FPL). Clients receiving transportation EASY Tickets must be documented as having been properly screened for other public sector funding as appropriate every six (6) months. While clients qualify for and can access other public funding for transportation services, they will not be eligible for Ryan White Part A-funded transportation EASY Tickets.