Committee Reports to the Miami-Dade HIV/AIDS Partnership

Presented March 18, 2024

This report contains nineteen (19) motions and an overview of each committee's activities for the meeting date(s) indicated.

Referenced attachments are posted online at www.aidsnet.org/the-partnership#partnership1, and a physical copy is available at the meeting.

CARE AND TREATMENT COMMITTEE – JANUARY 11, 2024, FEBRUARY 8, 2024, AND MARCH 14, 2024

19 MOTIONS

Members:

- Elected Dr. Mary Jo Trepka as Chair and Rick Siclari as Vice Chair.
- Heard updates from Ryan White Program Part A, Ryan White Part B, AIDS Drug Assistance Program (ADAP), and General Revenue.
- Continued work on developing new service definitions for the additional services approved in September.
- Reviewed and approved updates and revisions to current service definitions.
- Heard updates from the Medical Care Subcommittee (MCSC) including the election of James Dougherty as MCSC Chair and Cristhian Ysea as MCSC Vice Chair.
- Reviewed and approved several motions from the Medical Care Subcommittee.

Miami-Dade County Ryan White Program Minimum Primary Care Standards
Attachment #1

#	Motion	Details
1	**Motion to accept the Miami-Dade County Ryan White Program Minimum Primary Medical Care Standards with the substitution of** "physician assistant" for the former term, "physician associate". ▪ *Attachment #1*	Standards were reviewed and updated, specifically changing "physician assistant" to "physician associate" which is the current terminology. Standards are well established, and changes tend to be incremental. Look for the red underlined text in the attachment for updates.

FY 2024 Ryan White Program Service Definitions
Attachments #2 - #13

#	Motion	Details
2	**Motion to accept the changes to the FY 2024 service definition for AIDS Pharmaceutical Services, as presented.** ▪ *Attachment #2*	Service definition drafts for **ten** (10) services for FY 2024 were reviewed, edited for content, and updated as presented in the attachments. Standards are well established, and changes tend to be incremental. Look for the red underlined text in the attachments for updates. Look for the highlighted references in the attachments, which indicate pending updates based on soon to be published materials.
3	**Motion to accept the changes to the FY 2024 service definition for Mental Health Services, as presented.** ▪ *Attachment #3*	
4	**Motion to accept the changes to the FY 2024 service definition for Outpatient Ambulatory Health Services, as presented.** ▪ *Attachment #4*	
5	**Motion to accept the changes to the FY 2024 service definition for Other Professional Services: Legal Services and Permanency Planning, as presented.** ▪ *Attachment #5*	
6	**Motion to accept the changes to the FY 2024 service definition for Outreach Services, as presented.** ▪ *Attachment #6*	
7	**Motion to accept the changes to the FY 2024 service definition for Emergency Financial Assistance, as presented.** ▪ *Attachment #7*	
8	**Motion to accept the changes to the FY 2024 service definition for Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (Health Insurance Assistance), as presented.** ▪ *Attachment #8*	
9	**Motion to accept the changes to the FY 2024 service definition for Medical Case Management, Including Treatment Adherence Services, as presented.** ▪ *Attachment #9*	
10	**Motion to accept the changes to the FY 2024 service definition for Medical Transportation, as presented.** ▪ *Attachment #10*	
11	**Motion to accept the changes to the FY 2024 service definition for Food Bank, as presented.** ▪ *Attachment #11*	

FY 2024 Ryan White Program Service Definitions
Attachments #2 - #13

#	Motion	Details
12	**Motion to accept the changes to the FY 2024 service definition for Oral Health Care as presented, pending review of the annual client expenditure cap by the Recipient.** ▪ *Attachment #12*	The FY 2024 Oral Health Care Service Definition draft was reviewed and approved. Last year there was no annual client expenditure cap. A cap may need to be set as a cost-containment measure. The cap is pending Recipient review. Look for the red underlined text in the attachments for updates. Look for the highlighted struck through language which is the cap language under review.
13	**Motion to change "physician" to "licensed medical provider" in all the service definitions.**	This language had been applied to some service definitions and should be made consistent throughout.
14	**Motion to accept the changes to the FY 2024 service definition for Substance Abuse Outpatient Care and Substance Abuse Services (Residential), as presented.** ▪ *Attachment #13*	The FY 2024 draft was reviewed, edited for content, and updated, as presented. Look for the red underlined text in the attachments for updates.

Miami-Dade County Ryan White Program
Minimum Primary Medical Care Standards

Statement of Intent: *All local Ryan White Program—funded practitioners are required by contract to adhere, at a minimum, to the Public Health Service (PHS) Guidelines. These standards serve as the minimum standards by which practitioners will be measured.*

I. Requirements

Requirements for New Practitioners (Physicians, Advanced Practice Registered Nurse, and Physician Assistants/Associates):

- New practitioners should be linked to existing Ryan White Program providers, AIDS Education and Training Center (AETC) or through an American Academy of HIV Medicine (AAHIVM) specialist to support the new provider.
- New providers will receive a chart review within 6 months by supervising physician, medical director or agency team.
- When a new practitioner is working with a contracted practitioner, new practitioner is encouraged to comply within one year to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits.

Requirements for All Practitioners (Physicians, Advanced Practice Registered Nurse, and Physician Assistants/Associates):

- Practitioners are strongly encouraged to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits within a period of two years.

Practitioner must:

- Be a Physician (MD or DO), Advanced Practice Registered Nurse, or Physician Assistant/Associates with current and valid license to practice medicine within the State of Florida.
- Have a minimum experience treating 20 HIV+ clients over the past two years or currently working and under supervision of a practitioner meeting these qualifications.
- Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
  a. **American College of Cardiology/American Heart Association Guideline on the Treatment of Blood Cholesterol**
  https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625
  b. **Adult Immunization Schedule**
  https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
  c. **American Association for the Study of Liver Diseases**
  https://www.aasld.org/practice-guidelines
  d. **American Cancer Society Guidelines for the Early Detection of Cancer**
  https://www.cancer.org/healthy/find-cancer-early/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
  e. **American Medical Association Telehealth Quick Guide**

https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

f. **Department of Health and Human Services (DHHS) Clinical Guidelines** https://clinicalinfo.hiv.gov/en/guidelines
g. **Hepatitis (HEP) Drug Interactions University of Liverpool** https://www.hep-druginteractions.org/
h. **HIV Drug Interactions University of Liverpool** https://hiv-druginteractions.org/
i. **HIV Prevention with Adults and Adolescents with HIV in the US** https://www.cdc.gov/hiv/guidelines/recommendations/personswithhiv.html
j. **Health Resources and Service Administration (HRSA) HIV Care for People Aging with HIV** https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-best-team.pdf
k. **Infectious Disease Society of America Primary Care Guidance for Persons with HIV** https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/
l. **Miami—Dade County Ryan White Program (including Telehealth Policy and Test and Treat/Rapid Access [TTRA] program)** https://www.miamidade.gov/global/service.page?Mduid_service=ser1482944607068715
n. **National HIV Curriculum** https://www.hiv.uw.edu/alternate
o. **PrEP, nPEP and PEP guidelines below (Although not paid for by the Ryan White Program):** https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf https://www.cdc.gov/hiv/clinicians/materials/prevention.htmlhttps://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf
q. **United States (US) Preventive Taskforce** https://uspreventiveservicestaskforce.org/uspstf/home

- Follow an action plan to address any areas for performance improvement that are identified during quality assurance reviews.

II. Assessments and Referrals

1. Annual – At each annual visit:

a. Adherence to medications
b. Age-appropriate cancer screening
c. Behavioral risk reduction
d. Gynecological exam per guidance for females
e. Interval changes in vital signs addressed, especially trend in weight/BMI over time
f. Mental health and substance abuse assessment
g. Physical examination, including review of systems
h. Preconception counseling for men and women

i. Rectal examination
j. Safer sex practices – discussions may include PrEP, PEP, nPEP, for sexual partners and should include condom usage
k. Sexually transmitted infection assessment
l. Update comprehensive initial history, as appropriate
m. Vital signs, including weight, BMI, height (no shoes)
n. Wellness exam for females

Assess and document health education on:

o. Advance Directives (completion or review)
p. Birth control
q. Domestic violence
r. Drugs/Alcohol/Tobacco (including smokeless) assessment/care
s. Exercise
t. Frailty screening, as appropriate
u. Mental Health assessment (particularly clinical depression, care, mood, libido, sleep patterns, concentration, and memory)
v. Neurology and/or neuropsychology referral for assessment of neurocognitive disorders, dementia, and focal neuropathies, as appropriate
w. Nutritional assessment/care (including appetite), as appropriate
x. Oral health care

2. Additional Charting/Documentation at least annually:

a. Allergies list complete and up to date
b. Immunization list complete and up to date
c. Medications list complete with start and stop dates, dosages
d. Problem list complete and up to date

Item to be covered by subrecipient staff: If a client knows of others who need PrEP or Test and Treat / Rapid Access, information and referral are offered.

3. Initial – At initial visit:

a. Access to stable housing, food, and transportation
b. Adherence to medications
c. Age-appropriate cancer screening
d. Behavioral risk reduction
e. Comprehensive initial history
f. Dates of last: mammogram, bone density, colonoscopy, abnormal aortic aneurysm screening, dental visit, and dilated eye exam
g. Education that they should never run out of ART medications and need to call the FDOH—MDC clinic if they cannot obtain ART
h. Gynecological exam per guidance for females
i. If enrolled as Test and Treat/Rapid Access (TTRA) client (patient), follow TTRA protocol for visit
j. Mental health and substance abuse assessment
k. Physical examination, including review of systems

l. Pregnancy Planning:
   1) Preconception counseling for men and women
   2) Contraceptive counseling for men and women including assessment and type of birth control method
m. Rectal examination
n. Safer sex practices — discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage
o. Sexually transmitted infection assessment as appropriate including at a minimum GC, Chlamydia at anatomical sites of potential exposure, RPR, and for females trichomoniasis NAAT of vaginal secretions.
p. Social supports and disclosure history
q. Targeted initial history and physical examination with expectation that a complete history and physical examination will be completed within 3 months.
r. Vital signs, including weight, BMI, height (no shoes)
s. Wellness exam for females

Item to be covered by subrecipient staff: Documented HIV education, including transmission, reduction of morbidity/mortality with ART; resistance; compliance with ART and office visits and lab monitoring; life expectancy; divulging HIV status and state statute.

4. Interim Monitoring and Problem-Oriented visits – At every visit:
a. Adherence to medications and lab and office visits for monitoring
b. In women of childbearing age, assessment of adequate contraception
c. Interval changes in vital signs addressed, especially trend in weight over time
d. Interval risk for acquiring STD and screening as indicated
e. Physical examination related to specific problem, as appropriate
f. Risk reduction
g. Safer sex practices – discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage
h. Vital signs, including weight/BMI – may not occur every time with telehealth

5. Telehealth

Telehealth may be used in place or conjunction with an office visit. Necessary assessments will be conducted as needed and follow-ups will be scheduled, as appropriate.

III. Assessments at Incremental Visits

General Health including Labs

1. **ALT, AST, Total Bilirubin** [i] – Entry into care; ART initiation or modification; 4-8 weeks after ART initiation or modification; every 6 months; or if ART initiation is delayed, every 6-12 months; or if clinically indicated.

2. **Annual wellness visit** (females) [iv] – Should include screenings for anxiety, breast cancer, cervical cancer, interpersonal and domestic violence, obesity prevention (midlife women), sexually transmitted infections, urinary incontinence, and contraception. For those who are pregnant, lactation support and screenings for diabetes mellitus (including post-pregnancy), as applicable.

3. **Basic metabolic panel** [i] – Entry into care; ART initiation or modification; 4-8 weeks after ART initiation or modification; every 6 months; if ART initiation is delayed, every 6-12 months; or if clinically indicated. Serum Na, K, HCO_3, Cl, BUN, creatinine, glucose, and creatine-based estimated glomerular filtration rate. Serum phosphorus should be monitored in patients with chronic kidney disease who are on tenofovir disoproxil fumarate (TDF)-containing regimens. Consult the HIV Medicine Association of the Infectious Diseases Society of America's (HIVMA/IDSA) Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Patients Infected with HIV for recommendations on managing patients with renal diseases. More frequent monitoring may be indicated for patients with evidence of kidney diseases (e.g., proteinuria, decreased glomerular dysfunction) or increased risk of renal insufficiency (e.g., patients with diabetes, hypertension).

4. **Bone Densitometry** [iii] – Baseline bone DEXA should be performed in all greater than or equal to 50 years old postmenopausal women and men.

5. **CBC w/ differential** [i] – Entry into care; ART initiation or modification; every 3-12 months if monitoring CD4 count (if required by lab); or when clinically indicated. CBC with differential should be done when a CD4 count is performed. When CD4 count is no longer being monitored, the recommended frequency of CBC with differential is once a year. More frequent monitoring may be indicated for persons receiving medications that potentially cause cytopenia [e.g., trimethoprim-sulfamethoxazole (TMP-SMX)].

6. **Colon and Rectal Cancer Screening** [v] – Colorectal cancer screening recommended for individuals between 45-75 years of age. For ages 76-85 screening should be based on personal preference, life expectancy, overall health, and prior screening history. Those over 85 years old should no longer get colorectal cancer screening. Discussion should take place earlier (1) for those with a personal history of colorectal cancer or certain types of polyps, (2) for those with a family history of colorectal cancer, (3) for those with inflammatory bowel disease (ulcerative colitis or Crohn's disease), (4) for those with confirmed or suspected hereditary colorectal cancers syndrome, such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC), or for those for with a

personal history of getting radiation to the abdomen (belly) or pelvic area to treat a prior cancer.

7. **Glucose (Random or Fasting)** [i] – Entry into care; ART initiation or modification; treatment failure; or if clinically indicated. If random glucose is abnormal, fasting glucose should be obtained. HbA1C is no longer recommended for diagnosis of diabetes in person with HIV on ART, see American Diabetes Association Guidelines.

8. **Gynecological Exam** [vi] (females) – In women and adolescents with HIV, initiation of cervical cancer screening with cytology alone should begin within one year of onset of sexual activity, or if already sexually active, within the first year after HIV diagnosis but no later than 21 years of age. Cervical cancer screenings in women who are infected with HIV should continue throughout a woman's lifetime (i.e., not stopping at age 65 years). In women infected with HIV who are younger than 30 years, if the initial cytology screening result is normal, the next cytology screening should be in 12 months. If the results of three consecutive annual cervical cytology screenings are normal, follow-up cervical cytology screening should be every 3 years. Co-testing (cervical cytology and human papillomavirus [HPV] screening) is not recommended for HIV-infected women younger than 30 years. Women infected with HIV who are 30 years and older can be screened with cytology alone or co-testing. After women screened with cytology alone have had three consecutive annual test results that are normal, follow-up screening can be every 3 years. Women infected with HIV who have one negative co-test results (normal cytology and HPV negative) can have their next cervical cancer screening in 3 years. In women with HIV infection, co-testing results that are cytology negative, but HPV positive are managed as in the general population. Women with HIV who have cervical cytology results of low-grade squamous intraepithelial lesions or worse should be referred for colposcopy. For women with HIV infection who are 21 years or older and have atypical squamous cells of undetermined significance (ASC-US) test results, if reflex HPV testing results are positive, referral to colposcopy is recommended. If HPV testing is not available, repeat cervical cytology in 6-12 months is recommended, and for any result of ASC-US or worse on repeat cytology, referral to colposcopy is recommended. Repeat cytology in 6-12 months, but not HPV testing, is recommended for HIV-infected women younger than 21 years with ASC-US test results. Although not explicitly stated in the Panel guidelines, women with HIV infection who have ASC-US, HPV-negative results (whether from reflex HPV testing or co-testing) can return to regular screening.

9. **Hepatitis A Screening** [ii] – At initial screening, if non-immune, offer vaccination and after vaccination received do postvaccination serologic testing 1 or 2 months or at the next scheduled visit. After the second vaccine to assess for immunogenicity. A repeat vaccine series is recommended in those who remain seronegative.

10. **Hepatitis B Serology (HBsAb, HBsAg, HBcAb total)** [i] – At entry into care; at ART initiation or modification, in patients not immune to hepatitis B (HBV), consider retesting if switching to a regimen that does not contain tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide (TAF); as clinically indicated including before starting hepatitis C direct-acting antiviral (HCV DAA). If patient has HBV infection (as determined by a positive HBsAg or HBV DNA test result), TDF or TAF plus either emtricitabine (FTC) or lamivudine (3TC) should be used as

part other ART regiment to treat both HBV and HIV infections. If HBsAg, HBsAb, and HBcAb test results are negative, hepatis B vaccine series should be administered. Most patients with isolated HBcAb have resolved HBV infection with loss of HBsAb. Consider performing an HBV viral load test for confirmation. If the HBV viral load test is positive, the patient may be acutely infected (and will usually display other signs of acute hepatitis) or chronically infected. If the test is negative, the patient should be vaccinated. Refer to the HIVMA/IDSA's Primary Care Guidance for Person with HIV and the Adult and Adolescent Opportunistic Infection Guideline for detailed recommendations.

11. **Hepatitis C Screening (HCV antibody or, if indicated, HCV RNA)** [i] – At entry into care; every 12 months, for at-risk patients—injection drug users, person with a history of incarceration, men with HIV who have unprotected sex with men, and persons with percutaneous/parenteral exposure to blood in unregulated settings are at risk for hepatitis C (HCV) infection; or when clinically indicated. The HCV antibody test may not be adequate for screening in the setting of recent HCV infection (defined as acquisition within the past 6 months), or advanced immunodeficiency (CD4 count <100 cells/mm^3). HCV RNA screening is indicated in persons who have been successfully treated for HCV or who spontaneously cleared prior infection. HCV antibody-negative patients with elevated ALT may need HCV RNA testing.

12. **Lipid Profile** [i] – Entry into care;4-8 weeks after ART initiation or modification; consider 1-3 months after ART initiation or modification ; every 12 months if normal at baseline but with cardiovascular risk. If normal at baseline, every 5 years or if clinically indicated. If random lipids are abnormal, fasting lipids should be obtained. Consult the American College of Cardiology/American Heart Association's 2018 Guideline on the Management of Blood Cholesterol for diagnosis and management of patients with dyslipidemia.

13. **Lung Cancer Screening** [x] – Annually with low-dose computer tomography (LDCT) for patients aged 50-80 and in fairly good health, and currently smoking or have quit in the past 15 years, and have at least a 20 pack-year smoking history (e.g. 1 pack a day x 20 years or 2 packs a day x 10 years).

14. **Mammogram (**females) [vii] – Starting at age 40, screening recommended annually. After age 55 every 2 years or can continue yearly screening. Screenings should continue as long as a woman is in good health and is expected to live at least 10 more years.

15. **Pregnancy test** [i] (For people of childbearing potential) – At entry into care; ART initiation or modification or when clinically indicated.

16. **Prostate-specific antigen (PSA) Screening** [viii] (males) – PSA testing is an individualized decision to be made by clinician and patient based on current guidelines.

17. **TB Testing** [ii] – Entry into care or anytime there is concern of a recent exposure. Annual TB test is recommended if patient is deemed high risk (repeated or ongoing exposure to known active TB, after incarceration, after living in congregate setting, active drug user or other risk

factor for TB). If tested when CD4 < 200, repeat after CD4 increases to above 200. Testing using either tuberculin skin test or interferon—γ release assay.

18. **Urinalysis** [i] – Entry into care; or if clinically indicate e.g., in patients with chronic kidney disease (CKD) or diabetes mellitus (DM). Consult the HIV Medicine Association of the Infectious Diseases Society of America's (HIVMA/IDSA) Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Patients Infected with HIV for recommendations on managing patients with renal disease. More frequent monitoring may be indicated for patients with evidence of kidney disease (e.g., proteinuria, decreased glomerular dysfunction) or increased risk of renal insufficiency (e.g., patients with diabetes, hypertension). Urine glucose and protein should be assessed before initiating tenofovir alafenamide (TAF)-or tenofovir disoproxil fumarate (TDF)-containing regimens and monitored during treatment with these regimens.

HIV Specific

19. **ARV therapy is recommended and discussed** [i] – Risks and benefits are discussed including reduced morbidity and mortality and prevention of HIV transmission to others and if treatment initiated, follow-up with adherence. If refused, document in record and refer to ARTAS and or Department of Health Treatment Adherence Specialist.

20. **CD4 cell count** [i] – Entry into care; at ART initiation or modification; every 3-6 months during the first 2 years of ART, or if viremia develops while patient is on ART, or if CD4 count is <300 cells/mm^3; every 12 months after 2 years on ART with consistently suppressed viral load, CD4 count 300-500 cells/mm^3, if CD4 count >500 cells/mm^3: CD4 monitoring is optional; if ART initiation is delayed monitor every 3-6 months; if treatment failure or if clinically indicated. *In accordance with the HRSA HAB performance measures, the local program defines consistently suppressed viral load as <200 copies/ml.*

21. **Genotypic Resistance Testing (PR/RT Genes)** [i] – Entry into care; at ART initiation or modification; if ART initiation is delayed; treatment failure or clinically indicated. Standard genotypic drug-resistance testing in ART-naïve persons should focus on testing for mutations in the PR and RT genes. If transmitted INSTI resistance is a concern, or if a person has a history of INSTI use in PrEP or treatment, or a person presents with viremia while on an INSTI, providers also should test for resistant mutation in the IN gene. In ART-naïve patient who do not immediately begin ART, repeat testing before initiating of ART is optional if drug-resistance testing was performed at entry into care. In patients with virologic suppression who are switching therapy because of toxicity or for convenience, viral amplification will not be possible; see the Drug-Resistance Testing section for a discussion of the potential limitations and benefits of proviral DNA assays in this situation. Results from prior drug-resistance testing should be considered because they can be helpful in constructing a new regimen.

22. **Genotypic Resistance Testing (Integrase Genes)**[i] – Entry into care, if transmitted INSTI resistance is suspected or if there is a history of cabotegravir long acting (CAB-LA) use for PrEP ; at ART initiation or modification, if transmitted INSTI resistance is suspected or if there is a history of INSTI use; treatment failure if there is a history of INSTI use; or clinically indicated, if there is a history of INSTI use. Standard genotypic drug-resistance testing in ART-naïve persons should focus on testing for mutations in the PR and RT genes. If transmitted INSTI resistance is a concern, or if a person has a history of INSTI use in PrEP or treatment, or a person presents with viremia while on an INSTI, providers also should test for resistant mutation in the IN gene. In ART-naïve patients who do not immediately begin ART, repeat testing before initiation of ART is option if drug-resistance testing was performed at entry into care. In patients with virologic suppression who are switching therapy because of toxicity or for convenience, viral amplification will not be possible; see the Drug-Resistance Testing section for a discussion of the potential limitations and benefits of proviral DNA assays in this situation. Results from prior drug-resistance testing should be considered because they can be helpful in constructing a new regimen.

23. **HIV viral load** [i] – Entry into Care; at ART initiation or modification; 4-8 weeks after ART initiation or modification if HIV RNA is still detectable, repeat testing every 4-8 weeks until viral load is suppressed to <50 copies/mL. Thereafter, repeat testing every 3-6 months. For

patients on ART, viral load typically is measured every 3-6 months. More frequent monitoring may be considered in individuals having difficulties with ART adherence or at risk for nonadherence. However, for adherent patients with consistently suppressed viral load and stable immunologic status for more than 1 years, monitoring can be extended to 6-month intervals; if ART initiation is delayed, repeat testing is optional; or if treatment failure or if clinically indicated.

24. **HLA-B*5701** [i] – At ART initiation or modification if considering start of abacavir (ABC) and document in record carrying data forward to most current volume. *(Currently not paid for by the Ryan White Program due to payer of last resort restrictions; must access ViiV sponsored testing directly through labs. For LabCorp, HLA-AWARE HLA-B*5701 ViiV code #006940 and for Quest Diagnostic ViiV HLA-B*B5701 test code #19774).*

25. **Treatment of opportunistic infections and prophylaxis for opportunistic infections** [ii] – Specifically, but not limited to, Mycobacterium avium complex (MAC), Pneumocystis jirovecii pneumonia (PCP), and Toxoplasmosis (Toxo) prophylaxis per DHHS Guidelines.

26. **Tropism testing** [i] – At ART initiation or modification if considering use of CCR5 antagonist; or for treatment failure if considering a CCR5 antagonist, or if the patients with virologic failure on a CCR5 antagonist; or if clinically indicated. If performed, record carried forward to most current volume.

Immunizations

Document in medical record carrying data forward to most current volume

27. **COVID-19 vaccination** [ix] – Vaccinate per CDC guidance.

28. **Hepatitis A vaccination** [ix] – Offer vaccination if not immune per guidance. Assess for response 30-60 days after vaccination by performing Hep A IgG antibody or Hep A Total antibody.

29. **Hepatitis B vaccination** [ix] – Offer vaccination if not immune per guidance. Assess for response 30-60 days after vaccination by performing Hepatitis B surface antibody quantitative (anti-HBs).

30. **Human Papillomavirus (HPV) Vaccine** [ix] – HPV vaccination as indicate by current guidelines.

31. **Influenza vaccination** [ix] – Offer IIV4 or RIV4 annually.

32. **Meningococcal vaccination** [ix] – Use 2-dose series MenACWY (Menveo or MenQuadfi)) at least 8 weeks apart and revaccinate every 5 years if risk remains. See vaccination guidelines**.**

33. **Mpox vaccination** – Vaccinate per CDC guidance. See https://www.cdc.gov/poxvirus/monkeypox/vaccines/vaccine-basics.html

34. **Pneumococcal vaccination** –Vaccinate per guidelines**.** For guidance on which pneumococcal vaccine should be used to: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html.

35. **Tetanus, diphtheria, pertussis (Td/Tdap)** [ix] – One dose Tdap, then Td or Tdap booster every 10 years.

36. **Varicella** [ix] – Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD 4 count <200 cells/mm^3.

37. **Zoster vaccination** [ix] — Use 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2-6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). See vaccination guidelines for detailed information and considerations**.**

STI Screenings

38. **Anal Dysplasia Screening** [iii] – For all patients with HIV ≥35 years old, see information at https://www.hivguidelines.org/guideline/hiv-anal-cancer/?mycollection=hpv-care

39. **Bacterial STIs (Syphilis**, **N. gonorrhoeae** (GC), **C. trachomatis** (Chlamydia) and **parasitic STIs (Trichomoniasis)** [ii] – At the initial HIV care visit, providers should test all sexually active persons with HIV infection for curable STDs (e.g., syphilis, gonorrhea, and chlamydia) and perform testing at least annually during the course of HIV care. See information at https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

Footnotes

[i] Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines. Accessed on August 3, 2023.

[ii] Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/whats-new. Accessed on August 4, 2023.

[iii] Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America. https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/. Accessed August 4, 2023.

[iv] Women's Preventive Service Guidelines. https://www.hrsa.gov/womens-guidelines. Accessed August 3 2023.

[v] American Cancer Society Recommendations for Colorectal Cancer Screening. https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html. Accessed August 4, 2023.

[vi] Gynecologic Care for Women and Adolescents with Human Immunodeficiency Virus. The American College of Obstetricians and Gynecologist, vol. 128, no. 4, October 2016. https://pubmed.ncbi.nlm.nih.gov/27661659/. Accessed August 4, 2023.

[vii] American Cancer Society Recommendations for the Early Detection of Breast Cancer. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html. Accessed August 4, 2023.

[viii] American Cancer Society Recommendations for Prostate Cancer Early Detection. https://www.cancer.org/cancer/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html. Accessed August 4, 2023.

[ix] Recommended Adult Immunization Schedule for Ages 19 years or older, United States, 2024. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html. Accessed November 17, 2023.

[x.] American Cancer Society Recommendations for Lung Cancer. https://www.cancer.org/cancer/types/lung-cancer.html. Accessed August 4, 2023.

AIDS PHARMACEUTICAL ASSISTANCE
(LOCAL PHARMACEUTICAL ASSISTANCE PROGRAM – LPAP)

(Year 34 Service Priority: #8 for Part A)

A. **AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program – LPAP)** is a core medical service. The purpose of the **LPAP** component (i.e., prescription drug services) of the AIDS Pharmaceutical Assistance service FFcategory, 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.

This service includes the provision of medications and related supplies prescribed or ordered by a licensed medical provider (MD, DO, APRN, PAs) to prolong life, improve health, or prevent deterioration of health for people with HIV 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. Supplies are limited to consumable medical supplies necessary for the administration of prescribed medications.

IMPORTANT NOTES: Services are restricted to outpatient services only. Inpatient, emergency room, and urgent care center prescription drug services are not covered. Vaccines provided during a medical office visit are no longer found in the local Ryan White Part A Program Prescription Drug Formulary but may be available under Outpatient/Ambulatory Health Services. Prescription drug copayment 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). See the General Revenue Short-term Medication Assistance protocol in Section XII of this FY 2024 Ryan White Program Service Delivery Manual for information on how to access to medications on a short-term, emergency basis.

1. **Medications Provided:** This service pays for injectable and non-injectable prescription drugs, pediatric formulations, 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 local Ryan White Part A Program Prescription Drug Formulary, with the Ryan White Part A/MAI Program as the payer of last resort. The local Ryan White Part A 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 Licensed Medical Providers, 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, Licensed Medical Provider, 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 licensed medical provider visits, or is having other difficulties with treatment adherence).

- Providers are expected to ensure immediate follow-up with clients who miss their prescription refills, licensed medical provider 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 Licensed Medical Provider, 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 Licensed Medical Provider and found to be suffering from an illness that significantly limits the client's capacity to travel [condition is valid for the period indicated by the Licensed Medical Provider or for sixty (60) calendar days from the date of certification].

IMPORTANT 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.

- Providers of this service are expected to be Covered Entities authorized to dispense PHS 340B-priced medications either directly, through an allowable subcontract arrangement, or via another federally acceptable affiliation.

  - Clients needing this service may only go to, or be referred to, the pharmacy in which their HIV/Primary Care Provider or prescribing practitioner is located or affiliated with (e.g., by subcontract, etc.). This is due to PHS 340B Pharmacy drug pricing limitations, and HRSA's requirements that the Ryan White Part A/MAI Program use PHS 340B drug pricing wherever possible.

  - If the provider is a PHS 340B covered entity and the client is enrolled in the Florida 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 LPAP-funded 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 In Network Referral for LPAP Services is not required. However, to access LPAP services, the client must be open at the LPAP-funded agency and must have their Client Service Category Profile in the Provide® Enterprise Miami data management system open to Outpatient/Ambulatory Health Services at the same agency. This is due to 340B covered entity drug pricing requirements.

Ryan White Program-funded LPAP services have a maximum of one year from the date on the prescription.

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 program-allowable 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 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 budget narrative.

- Reimbursement for consumable medical supplies is limited and must be related to administering 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 (i.e., through reimbursement requests) in terms of the individual drugs dispensed (utilizing a locally-defined drug coding system 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 local Ryan White Part A Program Prescription Drug Formulary.

Provider monthly reports (i.e., reimbursement requests) 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 Part A Program Prescription Drug Formulary:** Ryan White Program funds may only be used to purchase or provide vitamins, appetite stimulants, and/or other prescription medications to program clients as follows:

- Prescribed medications that are included in the most recent release of the Ryan White Part A Program Prescription Drug Formulary. This formulary is subject to periodic revision; and

- Medications, appetite stimulants, or vitamins that have been prescribed by the client's Licensed Medical Provider. **IMPORTANT NOTE**: Prescriptions for vitamins may be written for a 90-day (calendar days) supply.

F. **Letter of Medical Necessity: Continuous Glucose Monitoring (CGM) Devices** require a completed Ryan White Letter of Medical Necessity (LOMN) (See Section V of this FY 2024 Service Delivery Manual for copies of the Letters of Medical Necessity, as may be amended).

ADDITIONAL IMPORTANT NOTES:

- **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 copayments 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 2024 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.**

- **AS OMB RECEIVES ADDITIONAL INFORMATION FROM FEDERAL FUNDERS AND/OR STATE LEGISLATIVE BODIES REGARDING IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), HEALTH EXCHANGES, OR ANY SUBSEQUENT HEALTH CARE LAW, THIS MANUAL MAY BE**

REVISED.

MENTAL HEALTH SERVICES

(Year 34 Service Priorities: #3 for Part A and #3 for MAI)

Mental Health Services are a set of core medical services that consist of counseling and treatment for diagnosed behavioral health disorders. These services are designed to reduce harmful behaviors and episodes of instability and improve mental status and client health outcomes. These Mental Health Services include the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to people with HIV. Services are based on an individualized treatment plan and are conducted in group and individual sessions. All services are provided by mental health professionals licensed or otherwise authorized within the State of Florida to render such services. All clients receiving this service must have at least one mental or behavioral health diagnosis specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or International Classification of Disease, Tenth Revision, Clinical Modification (ICD-10-CM; Codes F01-F99, excluding "Mental and behavioral disorders due to psychoactive substance use" – codes F10-F19).

Mental Health Services require an individualized treatment plan, as noted above. Treatment plans incorporate the findings of assessment and diagnostic tools and specify the goals and objectives to be achieved during the treatment episode. The treatment plan also specifies the recommended clinical interventions and frequency with which these interventions shall be delivered. Mental health providers may use this service category to conduct the assessment and diagnostic steps for the development of a treatment plan. If ongoing mental health services are being provided to a client, it is expected that the client receives a mental health treatment plan at least every six months.

Psychiatric treatment with medication management and evaluation should be billed and recorded under Outpatient/Ambulatory Health Services. Additional mental health services may be billed under Outpatient/Ambulatory Health Services when provided by a licensed psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner or physician assistant/associate.

Mental Health Services are allowable only for program-eligible clients. This service is not available to family members without HIV. Ryan White Program funds may **not** be used for bereavement support for uninfected family members or friends.

Mental Health Services reimbursed under Part A or MAI of the Ryan White Program are limited to conditions impacting the treatment of the client's underlying HIV disease (e.g., assessing, diagnosing, and treating a mental health condition that hinders HIV treatment adherence) and treated within the context of the client's HIV or AIDS diagnosis. This service is intended to address issues that impact a person's ability to remain engaged in HIV care, strengthen coping skills and self-care, and promote engagement in ongoing medical care and treatment. It is important for the Level I or Level II mental health

professional to regularly gauge and document the client's progress and determine if the client is still in need of the service.

- **Mental Health Services (Level I):** This level includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess ***a Doctorate degree*** **in psychology or counseling or related field (PhD, EdD, PsyD), and must be *licensed by the State of Florida*** as a Licensed Clinical Psychologist, LCSW, LMHC, or LMFT to provide such services.

- **Mental Health Services (Level II):** This level includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess ***a Master's degree*** **in psychology, psychotherapy or counseling or related field (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 must provide services under the supervision of a LCSW, LMHC, LMFT or Licensed Psychologist who is licensed in the State of Florida.

Mental Health Service Components:

Level I counseling services provided to Ryan White Program clients 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 program-eligible people with HIV (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].

Level II counseling services provided to Ryan White Program clients 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 program-eligible people with HIV (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 Program 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 program-eligible client is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of group counseling participants to counselors may not be lower than 3:1 and may not be higher than 15:1, as described above. One visit is equal to one half-hour counseling session.

Clients who are newly diagnosed with HIV or have returned to care should be offered the opportunity to speak with a mental health provider as a routine component of the services available through the local Ryan White Part A Program. An initial mental health visit could be used to identify, assesses, or verify mental health conditions that may affect a client's treatment adherence. Subsequent or on-going Mental Health Services under the Ryan White Part A Program require a mental health diagnosis documented in the client's chart. To facilitate this process for newly diagnosed or returned to care clients who are receiving TTRA mental health services are limited to one encounter (all mental health services provided on one day) within 30 days of starting the TTRA protocol, while program eligibility is being determined. For clients following the Newly Identified Client (NIC) protocol, Mental Health Services may be provided with these same limitations.

Tele-mental health services are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

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 FY 2024 Service Delivery Manual for details, as may be amended.)

C. **Rules for Reimbursement:** Reimbursement for individual and group Mental Health Services will be based on a half-hour counseling session "unit" 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 counseling (i.e., number of group counseling units per counselor).

Tele-mental health services are reimbursed as follows:

Billing Code	Description	Flat rate Reimbursement
THMHT1	Tele-Mental Health provided by a Level I provider (individual client only)	$32.50 per 30-minute session
THMHT2	Tele-Mental Health provided by a Level II provider (individual client only)	$32.50 per 30-minute session

D. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group Mental Health Services 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 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 staff or authorized persons upon request. Client charts **must** include a specific mental or behavioral health diagnosis and detailed treatment plan for each eligible client that includes all required components and the mental health professional's signature and/or the signature of the person supervising the professional.

F. **Additional Treatment Guidelines and Standards:** Providers of Mental Health Services (Levels I and II) will adhere to generally accepted clinical guidelines for mental health therapy/counseling of people with HIV. The following are examples of such guidelines:

- American Psychiatric Association (APA). HIV Psychiatry - Training and Education, as well as HIV Psychiatry Resources and Publications [e.g., Fact Sheets (Last Updated: 2012): HIV and Clinical Depression; HIV and Anxiety; HIV and Cognitive Disorders; HIV and Delirium; HIV and Substance Use; HIV and People with Severe Mental Illness (SMI); Sleep Disorders and HIV; and Pain in HIV/AIDS; Publications (including links to other related books and journals, such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition - DSM-5); and additional web-based materials. Available at:

  https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv-psychiatry and
  https://www.psychiatry.org/psychiatrists/search-directories-databases
  Accessed 11/13/2023.

- American Psychiatric Association. Latest Published and Legacy APA Clinical Practice Guidelines; including, but not limited to, The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition, 2015. Available at:

  https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines and https://psychiatryonline.org/guidelines
  Accessed 11/13/2023.

OUTPATIENT/AMBULATORY HEALTH SERVICES

(Year 34 Service Priorities: #2 for Part A and MAI)

A. **Outpatient/Ambulatory Health Services** are core medical services. These services include primary medical care and outpatient specialty care required for the treatment of people with HIV or AIDS. These services focus 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 prescription drug therapies, including prophylaxis and treatment of opportunistic infections (OI) and combination ARV therapies.

IMPORTANT NOTE: Services are restricted to outpatient services only.

For the outpatient medical services to be considered Ryan White Program allowable, such services must be provided in relation to a client's HIV+ diagnosis, co-morbidity, or complication related to HIV treatment. This program allowable relationship must be clearly documented in the client's medical chart, in the Primary Care Provider's referral to specialty care services, and in any corresponding Ryan White Program In Network Referral or general Out of Network Referral. A list of the most current Allowable Medical Conditions, as may be amended, is included in Section VIII of this FY 2024 Service Delivery Manual for reference. For clarity, one or more of the listed conditions along with one of the following catch-phrases should be included in the Licensed Medical Provider (MD, DO, APRN, PAs) 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 this 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)
    - The SOC should be implemented 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 Manual document or other local guidelines, as may be amended.

Telehealth services are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

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 Assistant/Associates, Clinical Nurse Specialist, Nurse Practitioner, Advanced Practice Registered Nurse, or other health care professional who is licensed in the State of Florida to practice medicine 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 rooms are not considered outpatient settings; therefore, emergency room services are not covered by the Ryan White Part A/MAI Program. Inpatient (hospital, etc.) services are also not covered.**

Although HRSA allows for urgent care center services to be payable through the Ryan White Program, non-HIV related visits to urgent care facilities are not allowable or reimbursable costs within the Outpatient/Ambulatory Health Services Category (see HRSA Policy Clarification Notice #16-02). The Miami-Dade HIV/AIDS Partnership, as advised by its Medical Care Subcommittee, has elected not to include this component as an allowable service locally. This decision was made due to the complex logistics involved in limiting this component to the treatment of HIV-related services, as required by HRSA; and the fact that Ryan White Part A/MAI Program-funded Outpatient/Ambulatory Health Services subrecipients are required to maintain procedures (i.e., an accessible phone line for clients to call for assistance) for clients who have urgent/emergent health issues after hours.

Allowable activities include: medical history taking; physical examination; diagnostic testing, including, but not limited to, laboratory testing; treatment and management of physical and behavioral health conditions; behavioral risk assessment, subsequent counseling, and referral; preventive care and screening; pediatric development assessment; prescription and management of medication therapy; treatment adherence; education and counseling on health and prevention issues; and referral to specialty care related to client's HIV diagnosis, co-morbidity, or complication of HIV treatment. Services also include 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 specialty care (including all medical subspecialties if related to the client's HIV diagnosis, co-morbidity, or complication of HIV treatment), as necessary. Chronic illnesses usually treated by primary care providers include hypertension, heart failure, angina, diabetes, asthma, chronic obstructive pulmonary disease (COPD), depression, anxiety, back pain, thyroid dysfunction, and HIV.

Visits to ensure readiness for and adherence to complex HIV treatments shall be considered either billable under Medical Case Management or Outpatient/Ambulatory Health Services, depending on how the visit occurred. Treatment Adherence Services provided during an Outpatient/Ambulatory Health Service visit shall be reported under the Outpatient/Ambulatory Health Services category (using the appropriate CPT billing code); whereas Treatment Adherence Services provided during a Medical Case Management visit shall be reported in the Medical Case Management service category (using the ADH billing code).

a. New to Care Clients

One (1), initial primary medical care visit may be provided to a newly identified client (i.e., a newly diagnosed 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.

b. Limitations on Specialty Testing

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 any other payer source, clients must access the test through those resources first.

ViiV Healthcare currently covers the cost of the following test at no charge to eligible clients or the Ryan White Program: 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). 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. As of December 1, 2019, FDOH/ADAP clients do not need certificates for HLA Aware program. They simply use either their designated Quest Diagnostic lab or LabCorp code (that was listed on their certificates) for reimbursement by ViiV Healthcare. Contracted providers that serve FDOH/ADAP clients do not need to send clients to FDOH/ADAP, they just need to enter the appropriate code depending on which lab they use. FDOH already has this code as part of their EHR system. The Ryan White Program must be the payer of last resort. Utilization of the 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, Physician Assistants, Advanced Practice Registered Nurses, 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, medical appointments, and/or who experience difficulties with treatment 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.

- Mental health services may be billed under Outpatient/Ambulatory Health Services when provided by a licensed psychiatrist or other licensed medical provider (MD, DO, APRN, PAs), clinical psychologist, clinical social worker, or clinical nurse specialist.

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 program-eligible clients who are referred by a primary care provider through a Ryan White Program In Network 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, co-morbidities, or complications of HIV treatment (see Allowable Medical Conditions List in Section VIII of this FY 2024 Service Delivery Manual).**

Additional medical services, which may be provided by other Ryan White Program subrecipients, may include outpatient rehabilitation, podiatry, physical therapy, occupational therapy, and speech therapy as related to the client's HIV diagnosis, co-morbidities, or complications of HIV treatment. Pediatrics and specialty pediatric care are included in the list of specialties above. A Mental Health Services provider may also make referrals to clinical psychiatry. (**IMPORTANT NOTE**: Referrals to outpatient specialty care services for ongoing treatment must include documentation or a notation to support the specialty's relation to the client's HIV diagnosis, co-morbidity, or complication of HIV treatment.)

a. Other Specialty Care Limitations or Guidelines:

i. **Chiropractic services** under the Ryan White Program are limited to services in relation to the client's HIV diagnosis. These services may relate to pain caused by the disease itself or pain that is a consequence of HIV medications. Chronic pain is also considered a co-morbidity to HIV and may also be treated when appropriate. Chiropractors affect the nervous system and immune system by utilizing spinal adjustments and physiotherapy to the spine and body that may assist the nervous system in operating to the best of its ability to fight HIV-related infection, disease, and symptomatology. Chiropractic physicians may adjust, manipulate, or treat the human body by manual, mechanical, electrical or natural methods; by the use of physical means or physiotherapy, including light, heat, water, or exercise, or by the administration of foods, food concentrates, food extracts, and items for which a prescription is not required. Chiropractic services for non-HIV related injuries or conditions are not covered. Examples of non-HIV related injuries or conditions are slip and falls, car accidents, sports injuries, and acute pain.

ii. **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). The local Ryan White Part A/MAI Program will reimburse providers for the diagnostic evaluation of foot and ankle pain. Podiatry services for the treatment of peripheral neuropathy, HIV-related medication side effects (e.g., HAART/protease inhibitor medication regimens may cause ingrown toenails), onychomycosis, and diabetic foot care due to circulatory problems will be covered by the County's Ryan White Program. Conditions such as hammer toes, bunions, heel spurs may be covered if related to neuropathies. Sprains or fractures are not covered unless a direct connection to neuropathies is present. Furthermore, 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.

iii. **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. An annual eye exam solely for the purpose of routine eye care (especially for vision correction with glasses or contact lenses) is <u>not</u> covered by the local Ryan White Part A/MAI Program. In accordance with the most current local Ryan White Part A Program's Allowable Medical Conditions list, as may be amended, clients must

meet at least one of the following criteria to access ophthalmology/optometry services:

- Client has a low CD4 count (at or less than 200 cells/mm^3 *currently*
- Client has a comorbidity (e.g., diabetes, hypertension, STI, etc.)
- Client has a prior diagnosis of cytomegalovirus retinitis (CMV)
- Client has Immune Reconstitution Syndrome

Furthermore, referrals to an optometrist or ophthalmologist must indicate a condition attempting to rule out complications of HIV. See the Allowable Medical Conditions List in Section VIII of this Service Delivery Manual for a list of conditions that would apply, such as manifestations due to opportunistic infections, visual disturbances to rule out complications of HIV, and history of sexually transmitted infections (STI) or complications of STI.

iv. Per Federal guidelines, **acupuncture services** are <u>not</u> covered under this service category, as Ryan White Program funds may only be used to support limited acupuncture services for program-eligible clients as part of substance abuse treatment services.

v. **Obstetric services:** Although the selection of a Ryan White Program-funded service provider is based on client choice, pregnant women should be referred to the University of Miami OB/GYN Department (Ryan White Part D Program, etc.) whenever possible due to its specialized care for this HIV population.

vi. **Pediatric, adolescent and young adult services:** 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 due to their specialized care for this HIV population and age group.

IMPORTANT NOTE: Under the local Ryan White Part A/MAI Program, primary medical care provided to people with HIV 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 or HIV 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.

The following subsections B. through I. are for both Primary and Specialty Care, unless otherwise noted:

B. Program Operation Requirements:

- Providers must offer, post, and maintain walk-in hours to ensure maximum accessibility to Outpatient/Ambulatory Health Services, 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 Medical 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 people with HIV (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.

- **For Outpatient Specialty Care Only:** A referral from the client's Primary Care Providers or HIV Physician is required for all program-allowable specialty care services. Referrals to Outpatient Specialty Care services must be issued through the Provide® Enterprise Miami data management system and must indicate whether the referral is for a diagnostic appointment/test or for ongoing medical treatment. If the specialty care referral is for ongoing medical treatment the referrals must include supporting documentation that the ongoing care is HIV-related, comorbidity-related, and related to a complication of HIV treatment, as detailed in the most current, local Allowable Medical Conditions list.

C. Additional Service Delivery Standards: Providers of Outpatient/Ambulatory Health Services will also adhere to the following guidelines and standards, as may be amended (please refer to Section III of this FY 2024 Service Delivery Manual for details):

- Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses (as amended and current); also see Section I, below.

- HAB HIV Performance Measures to include the following, as may be amended: (https://ryanwhite.hrsa.gov/grants/performance-measure- portfolio)
  - Frequently Asked Questions
  - Core
  - All Ages
  - Adolescent/Adult
  - Children
  - HIV-Exposed Children
  - Medical Case Management (MCM)
  - Oral Health [Care]
  - ADAP [AIDS Drug Assistance Program]
  - Systems-Level

- Minimum Primary Medical Care Standards

D. **Rules for Reimbursement:** Providers will be reimbursed for program allowable outpatient primary medical care and specialty care services as follows, unless a procedure has been disallowed or discontinued by the Miami-Dade County Office of Management and Budget-Grants Coordination:

- 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 "2023 Florida Medicare Part B Physician Fee Schedule (Participating, Locality/Area 04), revised/modified January 9, 2023." Codes 99205 and 99215 remain discontinued under this local Ryan White Part A/MAI Program. Code 99201 was also discontinued.

- Reimbursements for lab tests and related procedures will be based on rates no higher than those found in the "2023 Medicare Clinical Diagnostic Laboratory Fee Schedule, Calendar Year (CY) 2023 Quarter 1 (Q1) Release, added for January 2023, modified January 12, 2023."

- Reimbursements for injectables will be based on rates no higher than those found in the "2023 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, updated January 30, 2023 (payment limit column)."

- Reimbursements for medical procedures performed at Ambulatory Surgical Centers (ASC) will be no higher than the rates found in the "2023 Florida Medicare Part B ASC Fee Schedule, by HCPCS Codes and Payment Rates,

PDF dated January 5, 2023, electronic file modified January 11, 2023; 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 2023 (January 2023), corrected January 20, 2023 (note "b.01.20.23" in file name)." (Applies only to organizations with on-site or affiliated outpatient hospital centers).

    - Opposite to Medicare's procedure guidelines, the local Ryan White Program discontinued the use of HCPCS code G0463 (hospital outpatient clinic visit). It is necessary for the local Ryan White Program to track the level of service provided to clients; therefore, providers of OPPS-APC services should continue to use CPT codes 99202-99204 or 99211-99214, as applicable to the services provided, instead of G0463.

- 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 2.5.

- If the client is eligible for ADAP, that program should be accessed for genotype and phenotype testing if available.

- 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

AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program – LPAP) 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 the referenced Formulary).

- Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details regarding the reimbursement of telehealth/telemedicine services.

E. **Rules for Reporting:** Providers' monthly reports (i.e., reimbursement requests) for Outpatient/Ambulatory Health Services 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 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, a 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 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.

H. **Additional Client Eligibility Criteria:** Clients receiving Outpatient/Ambulatory Health Services must be documented as having been properly screened for other public sector funding as appropriate annually, every 366 days. (NOTE: The recertification period for ADAP and Part A is expected to be updated within this grant fiscal year, with no less than 30 calendar days' notice.) While clients qualify for and can access medical services through other public funding [including, but not limited to, Medicare, Medicaid, Medicaid Managed Medical Assistance

(MMA), or Medicaid Long-Term Care (LTC)], or private health insurance, they will not be eligible for Ryan White Part A Program-funded Outpatient/Ambulatory Health Services, except for such program-allowable services that are not covered by the other sources.

I. Additional Treatment Guidelines and Standards

Guidelines: Providers will adhere to the following clinical guidelines for treatment of HIV/AIDS specific illnesses (which can be found at https://clinicalinfo.hiv.gov/en/guidelines, unless otherwise noted below):

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv; pp 1-604; updated March 23, 2023. Accessed 11/13/2023.

- Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv; pp 1-671; updated April 11, 2023. Accessed 11/13/2023.

- Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/perinatal; pp 1-614; updated January 31, 2023. Accessed 11/13/2023.

- Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. National Institutes of Health, Centers for Disease Control and Prevention, HIV Medicine Association, and Infectious Diseases Society of America. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections; pp 1-670; updated September 25, 2023. Accessed 11/13/2023.

- Panel on Opportunistic Infections in Children with and Exposed to HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Children with or Exposed to HIV. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-pediatric-opportunistic-infections/updates-guidelines-prevention; pp 1-485; updated September 14, 2023. Accessed 11/13/2023.

- Guidelines Working Groups of the NIH Office of AIDS Research Advisory Council. Guidance for COVID-19 and People with HIV. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/guidance-covid-19-and-people-hiv/guidance-covid-19-and-people-hiv; pp 1-19; updated February 22, 2022. Accessed 11/13/2023.

- U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. Clinical Care Guidelines/Protocols, including the following, as appropriate: Guide for HIV/AIDS Clinical Care (2014), A Guide to the Clinical Care of Women with HIV (2013), A Guide for Evaluation and Treatment of Hepatitis C in Adults Coinfected with HIV (2011); and reference guides to help health care professionals as their aging population grows (e.g., "Incorporating New Elements of Care" and "Putting Together the Best Health Care Team". Available at: https://ryanwhite.hrsa.gov/grants/clinical-care-guidelines-resources#clinical-protocols. Date Last Reviewed: February 2022. Accessed 11/13/2023.

- Additional Education Materials (e.g., fact sheets, infographics and glossary) on HIV Overview; HIV Prevention; HIV Treatment; Side Effects of HIV Medicines; HIV and Pregnancy; HIV and Specific Populations; HIV and Opportunistic Infections, Coinfections and Conditions; and Living with HIV (including but not limited to finding HIV treatment services; Mental Health; Nutrition and Food Safety; and Substance Use). Available at: https://hivinfo.nih.gov/understanding-hiv/fact-sheets Accessed 11/13/2023.

- In addition, providers will adhere to other generally accepted clinical practice guideline standards, as follow:

  Standards:

  - Providers will inform clients as to generally accepted clinical guidelines for pregnant women with HIV, treatment of AIDS specific illnesses,

clients infected with tuberculosis, hepatitis, or sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

- Providers will screen for TB and make necessary referrals for appropriate treatment. In addition, providers will follow Universal Precautions for TB as recommended by the CDC. Providers will also screen for hepatitis, sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

IMPORTANT NOTE: FEDERAL FUNDERS AND/OR STATE LEGISLATIVE BODIES REGARDING IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), HEALTH EXCHANGES, OR ANY SUBSEQUENT HEALTH CARE LAW, THIS MANUAL MAY BE REVISED.

OTHER PROFESSIONAL SERVICES: LEGAL SERVICES AND PERMANENCY PLANNING

(Year ~~33~~ 34 Service Priority: #15 for Part A only)

Other Professional Services (Legal Services and Permanency Planning) are support services. Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Locally, this service category is limited to the provision of Legal Services and Permanency Planning to people with HIV or AIDS who would not otherwise have access to these services, with the goal of maintaining clients in health care. Legal Services are available 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.

Funds may also be used to support program-allowable services (e.g., legal assistance, filing fees, and fingerprinting fees, etc. to support legal name and identity changes) for gender affirming care. This support for gender affirming care aims to facilitate access to benefit programs and services for which a client may be eligible. This gender affirming care support may be included in one or more of the service areas listed below.

All legal assistance under Ryan White Part A Program funding 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 service 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 (SSDI and SSI) 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 standby guardianship, joint custody, or adoption.

- Permanency Planning – this component helps clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: the provision of social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney. This sub-component includes preparation of advance directives, healthcare power of attorney, durable powers of attorney, and living wills.

IMPORTANT NOTES:

- Adoption/Guardianship is related to Permanency Planning under HRSA Policy Clarification Notice #16-02; however, for local tracking purposes, it has been identified as a separate billable component.

- 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).

- HRSA's Program Letter titled "Gender-Affirming Care in the Ryan White HIV/AIS Program," dated December 16, 2021 (https://ryanwhite.hrsa.gov/grants/program-letters), addresses the importance of and allowable uses of funds to support gender-affirming care.

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 (or fraction thereof)* of legal consultation and/or advocacy provided by an attorney or paralegal at a rate not to exceed $90.00 per hour. Gender affirming care support does not have a separate billing code, as it is a component in one or more of the service areas listed in Section A, directly above.

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 Services and Permanency Planning providers must submit an annual written assurance that: 1) Ryan White Program funds are being used only for Legal Services and Permanency Planning 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 In Network Referral or an Out of Network Referral (a non-certified referral accompanied by all appropriate supporting documentation) is required for this service and must be updated annually. Providers must also document that program-eligible people with HIV (clients) receiving Ryan White Part A Program-funded Other Professional Services (Legal Services and Permanency Planning) are permanent residents of Miami-Dade County and have gross household incomes that do not exceed 400% of the 2023~~3~~4 Federal Poverty Level (FPL).

E. **Additional Rules for Documentation:** Client charts must include a description of how the Legal Service or Permanency Planning services are necessitated by the individual's HIV status, the provision of services, client eligibility (Ryan White Program In Network Referral or Out of Network Referral with supporting documentation), and the hours spent in the provision of such services.

OUTREACH SERVICES

(Year ~~33~~ 34 Service Priorities: #14 for Part A and #~~10~~7 for MAI)

I. Definition and Purposes of Outreach Services

Ryan White Program **Outreach Services** are support services. Ryan White Part A/MAI Outreach Services in Miami-Dade County will use targeted approaches to locate people with HIV who are in need of assistance accessing HIV care and treatment who are:

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

Ryan White Program Outreach Services are directed to those persons known to have HIV and consist of activities to: a) engage and enroll newly diagnosed clients into the system of care; b) assist people with HIV who are lost to care with re-entry into the care and treatment system; and c) assist people with HIV who are determined to be at risk of being lost to care with their retention and access to ongoing medical care and treatment.

Outreach programs must be: 1) conducted at times and in places where there is a high probability that people with HIV and/or persons exhibiting high-risk behavior will be nearby; 2) designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness; 3) planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort; and 4) targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection.

With implementation of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative and in collaboration with the Florida Department of Health in Miami-Dade County's (FDOH-MDC) 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 the time they receive their preliminary reactive test result (Referral/Consent for Outreach Linkage to Care) will be contacted by Part A or MAI Outreach Workers for linkage to care either through Medical Case Management or Outpatient/Ambulatory Health Services. Outreach Workers will enter all demographic and program-related information in the Provide® Enterprise Miami data management system 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 must be documented in the outreach progress note and labeled as a 30 and 60 day follow-up in the Provide® Enterprise Miami data management system

Once a lost-to-care or at risk of being lost-to-care client is located, or a newly diagnosed and/or never in care person with HIV is located, 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/Ambulatory Health Services. The outcome (e.g., connection to care or inability to locate the client) must be documented in the Client Profile in the Provide® Enterprise Miami data management system.

IMPORTANT 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 rapidly linking the client to care. However, it is still necessary to obtain a confirmatory HIV test result; however, within thirty (30) calendar days, Outreach Services (e.g., connecting a newly diagnosed client to Outpatient/Ambulatory Health Services 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. After which time a confirmatory HIV test result is required to continue serving the client. If the HIV positive status cannot be confirmed or the result is negative, any services provided to the client must be disallowed.**

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 or scanned into the Client Profile in the Provide® Enterprise Miami data management system.

IMPORTANT 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 (i.e., 2 business days) of such notice. During a public health emergency or extreme weather event the process to pick up the consent forms may be altered by the Florida Department of Health and/or the Miami-Dade County Office of Management and Budget-Grants Coordination. In such cases, outreach service providers will be notified in writing.

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. Additionally, an Outreach Episode of Care must be opened in the Provide® Enterprise Miami data management system to coincide with the first date of Outreach Services and the period covered by the related referral. Final Outreach Services must be provided within ninety (90) calendar days of the initial referral date. After the ninety (90) calendar day period, the Outreach Episode of Care must be closed in the Provide® Enterprise Miami data

management system. 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.

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 shall be referred to FDOH-MDC Linkage Specialist or Disease Intervention Specialist for appropriate follow up.

A. Newly Diagnosed or Never in Care Person with HIV

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 program-eligible 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/urgent care centers
    - 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 a 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-MDC'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/Ambulatory Health Services; this includes connecting clients who are not eligible for Ryan White Program-funded services to appropriate care under other funding sources. 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.

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 In Network Referral in the Provide® Enterprise Miami data management system 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 In Network 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 In Network 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, Physician Assistant/Associate, or Advanced Practice Registered Nurse may immediately and directly request outreach assistance for a client who meets any of the conditions listed directly below in Section B.3., or for similar circumstances (e.g., abnormal lab results, significant

~~2.~~ risk of non-

adherence to treatment regimen, 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 medical practitioner 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 pharmacy or a Medical Case Manager;
- Missing an appointment with the jail linkage or prison re-entry coordinator; and/or
- Missing a medical or social service appointment that the jail linkage or prison re-entry coordinator has scheduled.

IMPORTANT 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 In Network Referral or OON Referral from the Jail Linkage or Prison Re-entry programs

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 to determine the client's HIV status. The goal of this one-time referral is to assist with the coordination to an HIV testing site and for the outreach worker's efforts to be recorded into the Provide® Enterprise Miami data management system in the Outreach Registration screen. This is a **secondary** outreach function that will be monitored by OMB and <u>should not supersede</u> 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

D. Allowable Outreach Activities

1. Ryan White Part A/MAI-funded 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 In Network 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, Physician Assistant/Associate, or Advanced Practice Registered Nurse; or 4) by a letter or OON Referral from a jail linkage or prison re-entry coordinator as indicated in Section B 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 Provide® Enterprise Miami data management system;
- Conduct brief intakes for new clients referred from a state-licensed Counseling and Testing Site, jail linkage or prison re-entry coordinator and enter data into the Provide® Enterprise Miami data management system outreach registration screen;
- Upon receipt of a proper referral, review data in the Provide® Enterprise Miami data management system 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 program-eligible people with 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;
- Contact clients who have a history or are at risk of falling out of care (i.e. substance abuse history, homelessness, mental illness) during the 30 and 60 day follow-up period with the end of increasing retention in care;

- Conduct home visits to meet with a client for the purpose of connecting them to care;

  - **IMPORTANT NOTES**:

    - 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 **must** be transitioned to a Part A/MAI-funded outreach provider that is able to conduct home visits;

    - In cases of transfer due to the home visits, the new outreach provider agency replaces the previous outreach provider agency;

- 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 Provide® Enterprise Miami data management system the encounter should only be counted/recorded (i.e., OFFE, OTEL, ORFL, etc.) by the main Outreach Worker/agency that received the referral;

  - **IMPORTANT NOTE:** If a Peer Educator is the safety back-up, the Peer Educator must use the corresponding safety encounter code, PSFT, under the PESN billing category.

- Provide education on available care and treatment options and services for people with HIV who receive outreach services via a Ryan White Program In Network Referral, Jail linkage referral, Department of Corrections Certification or a Referral Consent Linkage to Care form 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 people with HIV as identified by the counseling and testing facility and verified by the Ryan White Part A/MAI Program;
- Coordinate and participate in planned outreach/testing events such as "Take Control Miami" in cooperation with the FDOH-MDC;
- 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.

E. 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 or general 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.

Ryan White Part A/MAI Program funds may not be used to pay for HIV counseling or testing under this service category. Ryan White Part A/MAI Outreach Services must be planned and delivered in coordination with local HIV prevention programs to avoid duplication of effort.

Outreach Workers may <u>not</u> conduct random searches in the Provide® Enterprise Miami data management system 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 In Network Referral. Searches conducted in the Provide® Enterprise Miami data management system to identify clients lost to care must be initiated by the Medical Case Manager or medical or pharmacy 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.

F. 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 a Provide® Enterprise Miami In Network 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 the Provide® Enterprise Miami data management system, 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; and

- 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 101 – Know Your HIV Status" video training [this training is available on-line at https://knowyourhivstatus.com/hiv-resources/]. Outreach Workers must attend periodic training provided by the Ryan White Program's Clinical Quality Management and Training Program provided by BSR. In addition, effective June 1, 2018, any new hire Outreach Worker or Outreach Supervisor under the Ryan White Part A or MAI Programs must complete all 13 of the Southeast AIDS Education and Training Center's (SE-AETC) web-based Medical Case Management Curriculum and Cultural Competency Curriculum modules as required and as may be amended by the local Ryan White Part A Program **prior to** being approved for Provide® Enterprise Miami User Access. These curricula modules are indicated on the local Ryan White Program's AETC Training Module Checklist and the modules can be accessed at the following website: https://www.seaetc.com/modules/. Time spent completing the SE-AETC training modules **cannot** be charged to the local Ryan White Part A/MAI Programs.

   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 medical 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 subpopulations (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. Use the appropriate code from the following table to record outreach services (listed in alphabetical order by code):

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Collateral Contacts	**OCOL**	Use this code to record all 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 Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Consultation	**OCON**	Only Outreach Supervisors may use this OCON code. This code shall be used to record activities associated with consulting with outreach staff on Ryan White Program-related client, supervisory, or quality management issues.
Documentation	**ODOC**	Use this code to record activities related to documenting any encounter in the Provide® Enterprise Miami data management system, 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. **IMPORTANT NOTE**: See subsection II.D. below regarding "Applicability to Local Ryan White Program Requirements" for staff supervising Ryan White Program-funded Outreach Workers.
Face to Face Encounter	**OFFE**	This encounter is defined as any time the Outreach Worker or Outreach Supervisor has direct contact with the client in person. The OFFE encounter includes activities that are conducted face-to-face with the client where no other encounter code is appropriate. OFFE may also include referral activities if done face-to-face with the client.
Chart Review Activity	**OREV**	Only Outreach Supervisors may use this OREV code. This code should be used 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. As of May 1, 2018, there is no longer a required number of hours of OREV code use. **IMPORTANT NOTE**: See subsection II.D. below regarding "Applicability to Local Ryan White Program Requirements" for staff supervising Ryan White Program-funded Outreach Workers.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Referral Activity	**ORFL**	Use this code to record outreach referral activities that do not fit in any other outreach encounter/ activity in this list.
Safety Back-up	**OSFT**	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 Provide® Enterprise Miami data management system 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.
Outreach Telephone Encounter	**OTEL**	Use this code to record telephone contacts.
Outreach Contact Travel Time	**OTVL**	Use this code to document travel time with or on behalf of the client that is specific to care coordination, linkage to care, retention or retention in care activities. In such cases, documentation in the client chart must include reason for travel in relation to care coordination, linkage to care, or retention in care.
Take Control Miami events	**TCM**	Use this code to record outreach activities conducted at authorized "Take Control Miami" events.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Training	**TRN**	Use this code to record and bill for time spent attending authorized Ryan White Program trainings (TRN), such as Outreach Worker trainings, County-approved Provide® Enterprise Miami data management system trainings, and Ryan White Program Subrecipient (Service 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 **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, AETC training modules, 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.

5. **Connection to Care.** Providers are expected to document the client's connection(s) to care in the Provide® Enterprise Miami data management system as evidenced by documentation on file at the outreach 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 Provide® Enterprise Miami data management system and/or analysis of outreach data conducted by BSR, as a Clinical Quality Management Program activity.

B. Rules for Reimbursement: Providers will be reimbursed 1/12th of the contract total, subject to penalties for non-performance (i.e., reduced payment based on not meeting the required percentage of connections to care), as detailed below. Under this service category, Payment Requests

(invoices) submitted (via mail, email or the Provide® Enterprise Miami data management system) without any recorded services will not be processed for payment without the County's prior approval. In months where this occurs, the County will automatically apply a $1/12^{th}$ penalty for the month without services and will not take into consideration this month for purposes of the quarterly performance review.

Reimbursement will be performance-based. Initially, payment will be made in equal monthly installments of the contract award for this service, as may be amended through Reallocation/Sweeps awards or reductions. Subrecipients' performance under this service category will be reviewed quarterly to ensure effective service delivery; whereby at least 50% of the clients contacted through Outreach Services during the quarter must be connected for the first time (for new to care clients) or re-connected (for lost to care clients) to Outpatient/Ambulatory Health Services and/or Medical Case Management services. Failure to reach this 50% quarterly performance goal will result in penalties (i.e., payment reductions), as follows:

% of Unduplicated Outreach Clients who were Connected / Re-connected to Care During the Quarter Reviewed	**% of Quarterly Reimbursement Totals Subrecipient is Authorized to Retain (i.e., no penalty applied) ***
50% or more	100%
45 – 49%	90%
40 – 44%	80%
35 – 39%	70%
30 – 34%	60%
25 – 29%	50%
20 – 24%	30%
0 – 19%	0%

IMPORTANT NOTES:

1) Adjustments (e.g., reductions, disallowances, etc.) will be made to reimbursements in monthly invoices following the quarter reviewed. Any adjustment will be made to one or more monthly reimbursement invoices in the subsequent months of the same grant fiscal year until the full amount of the penalty is recouped. For example, if only 36% of the outreach clients contacted/served in Quarter 1 – March to May – were connected to medical care and/or medical case management, the subrecipient would keep (retain) 70% of the amount reimbursed during that period and the amount of the penalty (i.e., 30% of amount reimbursed during the quarter) would be deducted from invoices between June and February until the full amount of the penalty is recouped.

2) Special circumstances (e.g., new hires, complexity of care for subpopulation served, COVID-19 restrictions, etc.) may be considered at the County's sole discretion for adjustments to any penalty reductions indicated in the table directly above.

3) Each Outreach Worker must be an approved user/provider in the local Ryan White Part A Program's MIS system (e.g., Provide® Enterprise Miami data management system) BEFORE their first service date. Approvals will no longer be made retroactively for this service category.

4) Reallocations/Sweeps actions will also be prospective, not retroactive.

5) If an Outreach Services budget includes a staff vacancy and that vacancy is not filled by the end of the next quarter reviewed, a proportionate amount will be deducted from the total award to reduce the amount allocated to the vacant position.

6) Sweeps requests for additional funds cannot be used to cover prior penalties.

7) These new percentage rates (see table directly above) will be closely monitored by the Recipient (i.e., Miami-Dade County) for effectiveness and may be subject to change.

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 Provide® Enterprise Miami data management system 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.

Outreach staff must follow all applicable requirements of this service category in the Provide® Enterprise Miami data management system which include the following: managing an Outreach Episode of Care; ensuring that an In Network or OON referral is opened for a client;

updating all client appointments evidencing connections to care; creating progress notes which fully document the client encounter; opening the Client Service Profile Record under the correct funding source; ensuring only eligible clients are served.

It is required that all staff working on Outreach Services review and become familiar with the Provide® Enterprise Miami user guides (manuals) titled "Outreach Services Program" and "Referrals: In Network Service and Out of Network" as part of their new outreach staff orientation and prior to providing outreach services. This practice will guide staff as they navigate and follow the requirements of this service category in the Provide® Enterprise Miami data management system with the goal of limiting unbillable services, which can affect the amount of reimbursement approved by the County if the service(s) entered cannot count towards the performance standards detailed above.

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 Manual, System-wide Standards of Care, and Clinical 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 provider's staff supervises 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 Manual, System-wide Standards of Care, and Clinical Quality Management Program activities.

EMERGENCY FINANCIAL ASSISTANCE

(Year 3~~3~~4 Service Priorities: #1~~2~~4 for Part A and #5~~6~~ for MAI)

Emergency Financial Assistance is a support service. Under the local Ryan White Part A and MAI Programs, Emergency Financial Assistance provides limited one-time or short-term provision of approved formulary HIV/AIDS-related medications only, either directly or through a voucher program, while a client's eligibility for medication assistance is pending with a third-party payer. Subrecipients must be a Ryan White Part A or MAI Program-funded subrecipient also receiving AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program) funding and must have a current Public Health Service 340B certification from the federal Office of Pharmacy Affairs. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Ryan White Part A or MAI Program funds for these purposes will be as the payer of last resort, and for limited amounts, use and periods of time.

Currently, these funds are limited to the provision of short-term access to antiretroviral medications (ARV) for clients participating in the Test and Treat / Rapid Access (TTRA) protocol. In such instances, these services would only be used when the Florida Department of Health's financial resources for ARV medications under the local TTRA protocol have been depleted and the client is not yet enrolled in ADAP. Only clients whose gross household income is at or below 400% of the Federal Poverty Level and have a pending application with a third-party payer (e.g., ADAP or private insurance) are eligible for this assistance. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. Direct cash payments or reimbursements to a program client are not permitted.

Medications in the TTRA protocol, as may be amended based on guidance from the Florida Department of Health in Miami-Dade County, include:

- Biktarvy®
- Descovy® + Prezcobix®
- Dovato®
- Symtuza®
- Tivicay® + Descovy®

Medications in the TTRA protocol for women of childbearing potential (or for women presenting with pregnancy potential on inadequate contraception), as may be amended based on guidance from the Florida Department of Health in Miami-Dade County, include:

- Tivicay® + Truvada®
- Tivicay® + Descovy®
- Prezista® + Norvir®

IMPORTANT NOTES:

1) Tivicay® (dolutegravir) replaced Isentress® as a regimen appropriate and recommended for women at all stages of pregnancy – conception to birth. Tivicay® may be used with either Truvada® or Descovy®. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission (the Panel) recommends dolutegravir (DTG) as a Preferred antiretroviral (ARV) drug throughout pregnancy and now also recommends DTG as a Preferred ARV for women who are trying to conceive. (2/10/2021)

2) Dovato® (dolutegravir/lamivudine) has clinical data on use in the Test and Treat scenario (STAT clinical trial). Dovato® samples or vouchers can be obtained from ViiV Healthcare pharmaceutical representatives for use in subrecipient clinic(s). As such, the Florida Department of Health cannot be invoiced for this medication.

3) Symtuza®; subrecipients / service providers may prescribe this medication, but they must use the voucher provided by Janssen Pharmaceuticals to cover the cost of this medication. As such, the Florida Department of Health cannot be invoiced for this medication.

4) Should the need arise (i.e., when Florida Department of Health's TTRA medication funds are depleted) to implement this service category, the funds available under this service category may increase through the Reallocations/Sweeps process. Furthermore, if this service category is implemented, the rules under AIDS Pharmaceutical Assistance (Local AIDS Pharmaceutical Assistance Program) apply, except for the allowable medications which are limited to the most current, locally-approved medications for the TTRA protocol.

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS (HEALTH INSURANCE ASSISTANCE)

(Year 3~~4~~2 Service Priority: #6 for Part A only)

Health Insurance Premium and Cost Sharing Assistance for Low-income Individuals (Health Insurance Assistance) is a core medical service category. This service category includes the provision of financial assistance paid on behalf of eligible clients living with HIV or AIDS to maintain continuity of health insurance or to facilitate receiving medical and pharmacy benefits under a health care coverage program (health insurance policy). As funded by the local Ryan White Part A Program, this service is available to assist low income, program-eligible clients with cost sharing out-of-pocket health insurance expenses (i.e., copayments and deductibles), where program-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.

For clients to obtain Ryan White AIDS Drug Assistance Program (ADAP)-funded health insurance premium assistance, the local Ryan White Part A Program must ensure that clients are selecting health coverage that, at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each, drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services (DHHS) Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services. The local Ryan White Part A Program must also assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV Outpatient/Ambulatory Health Services to ensure that purchasing health insurance is cost effective in the aggregate, and allocate funding to this service category only when determined to be cost effective.

In Miami-Dade County, Health Insurance Assistance is divided into two (2) major categories: 1) limited assistance with private health insurance, employer-sponsored health insurance, or ADAP Premium Plus wraparound assistance for clients with COBRA coverage, which is identified in program components I, III, and IV directly below; and 2) assistance with the Federal Health Insurance Exchange [i.e., Affordable Care Act (ACA) Marketplace], which is identified in program component II (II.A. through II.C.) 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.

Locally, stand-alone dental insurance assistance is not covered under this service category.

Health Insurance Assistance under this service category is available to program-eligible people with HIV (clients) only. If a Family Plan is selected, the Ryan White Program will only provide assistance, where applicable, for the program-eligible person with 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 person(s) with HIV [client(s)] are clearly indicated.

A Ryan White Program In Network 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. The client's insurance policy information including benefits, policy number, and billing ID number is required 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 2022~~2~~4 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. ADAP PREMIUM PLUS (INCLUDING COBRA), EMPLOYER-SPONSORED INSURANCE, PRIVATE HEALTH INSURANCE

I. ADAP Premium Plus Program

The ADAP Premium Plus program is a Florida Department of Health (FDOH) AIDS Drug Assistance Program (ADAP) service for eligible clients who need help paying their health insurance premiums, as well as medication copayments and deductibles for medications on the Florida ADAP Formulary at http://www.floridahealth.gov/diseases-and-conditions/aids/adap/adap-formulary.html. This assistance is available through ADAP to clients who meet ADAP eligibility requirements, are subsequently enrolled in ADAP, and continue to re-certify their eligibility in ADAP every six (6) months; and is subject to Florida ADAP rules, requirements, and limitations. (NOTE: The recertification period for ADAP and Part A is expected to be updated within this grant fiscal year, with no less than 30 calendar days' notice.)

Florida ADAP's Premium Plus program offers the following two (2) types of services:

- Assistance with Medication Copayments and Deductibles (ADAP Formulary medications only):
    - Available to eligible individuals enrolled in ADAP with the following insurance types only:
        - Medicare Part D
        - Medicare Advantage
        - Employer-sponsored insurance (group health insurance)

- Affordable Care Act (ACA) Marketplace health insurance policies where the premiums are paid by ADAP

- Full Benefit Assistance:

  - Assistance with premium payments and ADAP formulary drug copayments and/or deductible costs. ADAP offers full benefit assistance for individuals with the following insurance types only:

    - Employer-sponsored insurance (group health insurance)
    - COBRA (Consolidated Omnibus Budget Reconciliation Act)*
    - ADAP-approved ACA Marketplace health insurance plans*

***IMPORTANT NOTES:**

- The local Ryan White Part A Program does not provide premium or deductible assistance to clients in the ADAP Premium Plus program.

- Limited Part A copayment assistance is available only to ADAP Premium Plus clients with a COBRA or ADAP/Part A-approved ACA Marketplace health insurance plan. See Section II.A. through II.C. below.

  - This limited copayment assistance includes program-allowable doctor office visit copayments, lab and diagnostic copayments, and non-ADAP formulary prescription drug copayments (as long as the medication is on the local Ryan White Part A Prescription Drug Formulary); and within Part A Program limitations.

  - Clients with COBRA coverage (whether or not the COBRA plan is an ACA plan) or an ADAP/Part A-approved ACA Marketplace health insurance plan who need Part A assistance with these copayments may do so following the guidelines in Section II.B. ADAP/PART A ACA Wraparound Copayments, directly below. A Ryan White Program In Network Referral from a Ryan White Program Medical Case Manager, or an Out of Network Referral (with supporting documentation), is required to obtain this assistance. With such referral, a GAP Card reflecting "Premium Plus" wraparound coverage will be provided to eligible clients to facilitate the process.

  - The following billing codes must be used for ADAP Premium Plus clients where Part A is paying the following program-allowable copayments or deductibles:

- ADAP Premium Plus – Non-ADAP drugs, use billing code **APPDRG**
- ADAP Premium Plus – Doctor Office Visit, use billing code **APPOV**
- ADAP Premium Plus – Lab & Diagnostics, use billing code **APPLAB**

II. Local Implementation of the Affordable Care Act (Federal Health Insurance Exchange)

According to the Affordable Care Act (ACA), the current Federal healthcare law (which is subject to change), individuals must have healthcare coverage that meets Minimum Essential Coverage. Minimum Essential Coverage (MEC) is defined as the type of coverage an individual must 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 continue to 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 are eligible to 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 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 Florida AIDS Drug Assistance Program (ADAP) will be paying the ACA Marketplace health insurance premiums for the calendar years ~~2022 and 2023~~. In order to obtain this assistance, clients will need to enroll in ADAP, re-certify their eligibility in ADAP every 366 days, and remain adherent to their ARV treatment plan. (The Medical Case Manager will assist with the local Part A Program-approved enrollment process and will make appropriate referrals for Wraparound assistance to the contracted Ryan White Part A Health Insurance Assistance subrecipient (currently Miami Beach Community Health Center, Inc.) who will complete the process and make appropriate copayment and deductible 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 assist with the enrollment following the local Part A Program-approved enrollment process.

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 be submitted to the designated Centralized Enrollment Specialist (currently American Exchange LLC) for assistance with evaluating the health care plan options that meet the client's individual needs and are cost effective; then, identifying the best option(s) for the client.

Until further notice, 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. 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, where applicable, and submit copies of these returns and reconciliation reports to their Medical Case Manager for possible repayment to the Ryan White Program (Part A or ADAP). Clients who are not required to file an annual federal income tax return must submit to their Medical Case Manager at the time of ACA enrollment proof that they are not required to file taxes. 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 identify clients who qualify for an ACA exemption;
  - Note: Per local requirements, clients eligible to participate in the ACA Marketplace will need to enroll with the Florida AIDS Drug Assistance Program (ADAP for assistance with health insurance premium payments for 2022~~3~~4 and 2023~~4~~5 plan policies.)
- Inform ACA-eligible clients of the requirements to have Minimum Essential Coverage;
- Discuss the benefits of having health insurance with the ACA-eligible clients;
- Assist ACA-eligible clients with enrollment in the ACA Marketplace [accomplished locally through the designated Centralized Enrollment Specialist (i.e., currently, through American Exchange LLC)];
- Document ACA enrollments and non-enrollments; and
- Reconcile Advanced Premium Tax Credits with any related tax refunds.

If a client is found to be ACA-eligible but chooses not to enroll in a health insurance 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 Provide® Enterprise Miami data management system.

Clients must also be informed that the Ryan White Part A Program is not allowed to assist the clients with paying any fees/penalties from prior years that are associated with the client not having health insurance.

~~If a client was eligible to participate in an ACA Marketplace health insurance plan up to and including calendar year 2018, but chose not to enroll, the client may have been charged an "individual shared responsibility payment" by the United States Internal Revenue Service (IRS). (The fee is sometimes called the "penalty," "fine," or "individual mandate.") This penalty was no longer applicable beginning in calendar year 2020.~~

Clients are strongly encouraged not to enroll in an ACA Marketplace health insurance plan on their own and not to allow the ACA Marketplace to automatically reenroll them. Clients who enroll on their own or allow the ACA Marketplace to automatically re-enroll them may inadvertently choose a plan that is not cost effective, does not sufficiently cover their needs, or does not meet the ADAP program guidelines or limitations for assistance. Furthermore, ADAP clients who enroll on their own in the ACA Marketplace may lose all access to ADAP assistance with ADAP prescription drugs, ACA premiums, and ACA drug copayments; and <u>may lose access to Wraparound assistance with allowable copayments and deductibles from the Ryan White Part A Program.</u>

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 202~~2~~4 Ryan White Part A Program Service Delivery Manual):

- ACA Matrix
- ACA Assessment tool
- ACA Acknowledgment form
- ACA Decline form, when applicable (i.e., when a client chooses not to enroll in the ACA, use this form ONLY AFTER the benefits of obtaining health insurance have been fully explained to the client)
- ACA GAP Card
- Policy on Reconciliation of Advanced Premium Tax Credits
- Policy on Refunds

Referrals to Ryan White Part A Program Health Insurance Assistance (each component) will expire annually on the date the policy period ends. The client's assigned Medical Case Manager will receive a reminder prior to expiration of the referral.

Local Ryan White Part A Program assistance for ACA Marketplace health insurance plans is limited to Wraparound, program-allowable copayment and deductible assistance. No exceptions.

IMPORTANT NOTE: It is critical that all Ryan White Program Medical Case Managers: 1) follow proper and consistent directions from the Recipient (i.e., Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program) when screening clients for ACA participation, and 2) share a clear and appropriate message with clients regarding the local health insurance program's rules and limitations.

II.A. ADAP/Part A ACA Wraparound Project General Limitations and ADAP-approved ACA Plans

- Eligibility for this component extends to ADAP clients with incomes between 5075% and 400% of the Federal Poverty Level (FPL) for plan year 20224; for HIV- related, co-morbidity related and complications of HIV treatment related conditions only.

- Part A does **not** assist with these ACA premium payments, as these premiums are paid by the Florida ADAP.

- For Plan Year 20224, Part A has limited ADAP/Part A ACA Wraparound assistance to the following seventy-~~ixty-~~ three~~seven~~ **(7367)** ADAP/Part A-approved plans only:

  - These 7345 ACA health plans identified by the Florida Department of Health will be available for selection in Miami-Dade County, **but** final plan selection is limited to a plan from this list that best meets the needs of individual clients, based on each individual's responses included in the local ACA Assessment Tool, and are cost effective:

Issuer Name	Plan Marketing Name
Ambetter from Sunshine Health	Complete Gold
Ambetter from Sunshine Health	Complete SELECT Gold with Select Providers
Ambetter from Sunshine Health	Complete VALUE Gold
Ambetter from Sunshine Health	Complete VALUE Silver
Ambetter from Sunshine Health	Elite Bronze
Ambetter from Sunshine Health	Elite Gold
Ambetter from Sunshine Health	Elite SELECT Bronze with Select Providers
Ambetter from Sunshine Health	Elite VALUE Bronze

Issuer Name	Plan Marketing Name
Ambetter from Sunshine Health	Everyday Gold
Ambetter from Sunshine Health	Everyday Silver
Ambetter from Sunshine Health	Focused SELECT Silver with Select Providers
Ambetter from Sunshine Health	Focused Silver
Ambetter from Sunshine Health	Focused VALUE Silver
Ambetter from Sunshine Health	Standard Expanded Bronze
Ambetter from Sunshine Health	Standard Expanded Bronze Select
Ambetter from Sunshine Health	Standard Expanded Bronze VALUE
Ambetter from Sunshine Health	Standard Gold
Ambetter from Sunshine Health	Standard Gold Select
Ambetter from Sunshine Health	Standard Gold Value
Ambetter from Sunshine Health	Standard Silver
Ambetter from Sunshine Health	Standard Silver SELECT
Ambetter from Sunshine Health	Standard Silver VALUE
Florida Blue (BlueCross BlueShield FL)	BlueOptions Bronze 24J01-17
Florida Blue (BlueCross BlueShield FL)	BlueOptions Bronze 24J01-18s
Florida Blue (BlueCross BlueShield FL)	BlueOptions Gold 24J01-09
Florida Blue (BlueCross BlueShield FL)	BlueOptions Gold 24J01-12
Florida Blue (BlueCross BlueShield FL)	BlueOptions Gold 24J0I-20S
Florida Blue (BlueCross BlueShield FL)	BlueOptions Plantinum 24J0I-05
Florida Blue (BlueCross BlueShield FL)	BlueOptions Plantinum 24J0I-08
Florida Blue (BlueCross BlueShield FL)	BlueOptions Plantinum 24J0I-21S
Florida Blue (BlueCross BlueShield FL)	BlueOptions Silver 24J01-03
Florida Blue (BlueCross BlueShield FL)	BlueOptions Silver 24J01-07
Florida Blue (BlueCross BlueShield FL)	BlueOptions Silver 24J01-19S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Bronze 2139
Florida Blue (BlueCross BlueShield FL)	BlueSelect Bronze 2342S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Gold 1535
Florida Blue (BlueCross BlueShield FL)	BlueSelect Gold 1835
Florida Blue (BlueCross BlueShield FL)	BlueSelect Gold 2344S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Platinum 1451
Florida Blue (BlueCross BlueShield FL)	BlueSelect Platinum 1457
Florida Blue (BlueCross BlueShield FL)	BlueSelect Platinum 2345S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Silver 1443
Florida Blue (BlueCross BlueShield FL)	BlueSelect Silver 1456
Florida Blue (BlueCross BlueShield FL)	BlueSelect Silver 2343S

Issuer Name	Plan Marketing Name
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Bronze 24K02-23
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Bronze 24K02-26S
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Gold 24K02-20
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Gold 24K02-28S
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Plantinum 24K02-15
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Plantinum 24K02-29S
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Silver 24K02-21
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Silver 24K02-27S
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Bronze 2129
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Bronze 2312S
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Bronze 2329
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Connect Care Silver 2332
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Connect Care Silver 24M03-70
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Gold 1605
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Gold 2314S
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Gold 24M05-74
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Platinum 24M05-00S
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Platinum 24M05-75
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Silver 2017
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Silver 2237
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Silver 2313S
Molina Healthcare	Bronze 4
Molina Healthcare	Bronze 8
Molina Healthcare	Gold 1
Molina Healthcare	Gold 8
Molina Healthcare	Silver 1
Molina Healthcare	Silver 12 with First 4 Primary Care Visits Free
Molina Healthcare	Silver 8
Molina Healthcare	Silver 9

NOTE: These plans ~~may change for plan year 2023~~change annually. FDOH will only provide premium and ARV copayment assistance for ADAP-approved plans, by county.

II.B. ADAP/PART A ACA Wraparound Copayments

This health insurance component covers limited copayment assistance for eligible clients who are enrolled in ADAP and Part A AND have an active ACA Marketplace health insurance policy where the premium is paid by ADAP, where applicable and within program limitations as detailed below.

A. Program Operation Requirements:

- ADAP covers the prescription drug copayments for all medications on the most current Florida ADAP Formulary, for eligible ADAP/clients who have an active ACA Marketplace health insurance policy under ADAP/Part A-approved health insurance plans indicated above. 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 Project" component, eligible ADAP/Part A clients who have an active ACA Marketplace health insurance policy or a policy through COBRA (Consolidated Omnibus Budget Reconciliation Act), where ADAP pays the premiums for one of the ADAP- approved plans indicated above or pays the premium for a COBRA policy, may receive assistance with the following copayments, if the medical services are IN-NETWORK, OUTPATIENT/AMBULATORY, AND related to the client's HIV care and treatment needs, related co-morbidity, or complication of HIV treatment:

    - Physician or medical practitioner office visit copayments
    - Laboratory/Diagnostic copayments
    - Prescription drug copayments
        - Part A assistance is limited to medications found on the most current, local Ryan White Part A Program Prescription Drug Formulary. See the following web page, at the Prescription Drug Services section:
            - http://www.miamidade.gov/grants/ryan-white-program.asp#Prescription
        - This Part A assistance does **not** include medications found on the most current Florida ADAP Formulary.
        - 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 In Network Referral or Out of Network (OON) Referral (with appropriate back-up documentation), respectively, for the Part A Program health insurance assistance copayment component.

- **Prescription drug copayment assistance is not provided for clients with prescription drug discount cards.**

- **Part A ACA copayment assistance is limited to program-allowable services rendered within the geographic boundaries of Miami-Dade County, with the exception of mail order for prescription drug copayments, where applicable.**

- **Providers and services that are Out-of-Network for the insurance plan are not covered.**

- **See Section IX of this Service Delivery Manual for information regarding the use of the GAP Card to facilitate access to ACA Wraparound copayment assistance. Note the deadline for submitting claims to the Part A Program.**

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

- Billing code **ACADRG** must be used for ADAP/Part A ACA Wraparound clients for whom Part A is paying their allowable prescription drug copayments (i.e., non-Florida ADAP Formulary medications).

  Billing code **ACALAB** must be used for ADAP/Part A ACA Wraparound clients for whom Part A is paying their allowable laboratory and diagnostic copayments.

- Billing code **ACAOV** must be used for ADAP/Part A ACA Wraparound clients for whom Part A is paying their allowable doctor/medical practitioner office visit copayments.

C. **Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per ADAP/Part A ACA Wraparound copayment per client*. Providers 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.

II.C. ADAP/Part A Wraparound Deductible 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:** The Ryan White Part A Program may assist with ACA Marketplace health insurance deductible payments for eligible client. The Ryan White Program will cover deductibles under Part A as payer of last resort if and where ADAP is unable to cover the deductible expense. Note that ADAP only pays deductibles related to medications on its prescription drug formulary.

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 Program clients who have an ACA Marketplace health insurance plan AND ARE ADAP clients enrolled under the ADAP/Part A ACA Wraparound Project (i.e., where ADAP is paying the premiums).

C. **Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per ACA deductible per client*. Providers 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.

III. **<u>Health Insurance Deductibles</u>**

This health insurance component is available to help maintain a client's existing (non-ACA) 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 (e.g., Outpatient/Ambulatory Health Services, Mental Health Services, and Substance Abuse Services).

A. **Program Operation Requirements:** Under no circumstances shall payment be made directly to clients who receive this assistance. 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 non-ACA health insurance component, when applicable.

C. **Additional Rules for Reporting:** Monthly activity reporting for this non-ACA 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.

IV. Prescription Drug Copayments and Co-Insurance

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

A. **Program Operation Requirements:** Assistance for both (non-ACA) prescription drug copayments and co-insurance is restricted to those medications on the most current, local Ryan White Part A Program Prescription Drug Formulary, even if the medication is also on the ADAP Formulary. **Prescription drug copayment 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 copayment/co-insurance per client, plus a dispensing rate.* Billing code **COP** must be used for this non-ACA health insurance component, when applicable.

C. **Additional Rules for Reporting:** Monthly activity reporting for this non-ACA service must be in dollars *per prescription drug copayment/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 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.

MEDICAL CASE MANAGEMENT,
INCLUDING TREATMENT ADHERENCE SERVICES

(Year 3~~3~~4 Service Priorities: #~~2~~ 1 for Part A and #~~1~~ for MAI)

Medical Case Management, including Treatment Adherence Services (hereinafter referred to as Medical Case Management) are core medical services. The local Ryan White Program Medical Case Management service category has two (2) distinct components: **Medical Case Management and the Peer Education and Support Network (PESN)**. *Subrecipient providers ("providers") are required to offer both components of this service category.* Medical Case Management services help clients improve health outcomes. As such, Medical Case Management providers should be able to analyze the care that a client receives to ensure that the client is obtaining the services necessary to improve his, her or their health outcomes.

The Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) defines Medical Case Management as a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all methods of encounters (e.g., face-to-face meetings, phone contact, and any other documented forms of communication). Key activities include: 1) initial assessment of service needs (including review of medical, financial, social, and other needs, upon intake); 2) development of a comprehensive, individualized service plan (including coordination of services required to implement the plan); 3) timely and coordinated access to medically appropriate levels of health and support services and continuity of care; 4) continuous client monitoring to assess the efficacy of the care plan; 5) re-evaluation of the care plan at least every six months with adaptations as necessary or more often as needed; 6) ongoing assessment of the client's and other key family members' needs and personal support systems; 7) treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and 8) client-specific advocacy and/or review of utilization of services. In addition to providing the medically oriented services above, Medical Case Managers may also provide benefits/entitlement counseling and referral activities (to core medical and support services) by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare, Medicare Part D, State AIDS Drug Assistance Program, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the ACA Health Insurance Marketplaces/Exchanges).

Visits to ensure readiness for and adherence to complex HIV treatments shall be considered either billable under Medical Case Management or Outpatient/Ambulatory Health Services, depending on how the visit occurred. Treatment Adherence Services provided during a Medical Case Management visit shall be reported in the Medical Case Management service category (using the ADH billing code indicated below); whereas,

Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit shall be reported under the Outpatient/Ambulatory Health Services category (using the appropriate CPT billing code).

The purpose and objectives of Medical Case Management are: 1) to maintain the client in ongoing medical care and treatment to improve client health outcomes; 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; and 8) 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, among other training topics.

Locally, in addition to the key activities indicated above, Medical Case Managers are responsible for performing the following functions: 1) conducting the initial intake; 2) managing and coordinating referrals, assisting with initial appointments, and coordinating services identified in the care plan, etc.; 3) 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; 4) evaluating services provided to the client by all funding sources to determine consistency with the established care plan; 5) conducting secondary prevention; and 6) closing client cases when warranted and documenting the reason for case closure. Medical Case Managers should regularly use special client-related views and reports in the Provide® Enterprise Miami data management system 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. A CD4 lab test result is optional following the U.S. Department of Health and Human Services (DHHS) treatment guidelines.

Medical Case Managers are expected to review, understand, and comply with the related case management activities indicated throughout the service definition as stated above in the Health Insurance Assistance section of this Service Delivery Manual.

II. ***Peer Education and Support Network (PESN):*** At the option of the client, the Medical Case Management agency will assign a Peer (variously designated as PESN, Peer Educator, Peer Navigator, or Case Aide) who is a person with HIV to provide "peer support," including client orientation and education about health and social service delivery systems. These Peers 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, encouraging treatment adherence, as well as accompanying clients to initial appointments for medical care and other services. These Peers 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. These Peers are restricted from completing Ryan White Program In-Network Referrals, Plans of Care, and Health Assessments, as these are functions of a Medical Case Manager. These Peers may also provide basic stress management guidance to their clients. For a description of PESN Essential Functions, see Section VII of this Service Delivery Manual.

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

The Peer will have basic knowledge of HIV/AIDS services and receive the necessary training on HIV funding streams from the Peer's Medical Case Management agency and other resources.

As incentives for productivity, PESN subrecipient 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:** Subrecipient 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. Subrecipient providers of Medical Case Management services are expected to educate clients on the importance of complying with their medication regimens.

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, other medical practitioner, Nutritionist, Pharmacist, Mental Health or Substance Abuse Counselors, 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/their 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 FY 2023 Service Delivery Manual), as may be amended.

2. Provider Requirements:

a) Providers will be expected to report to Miami-Dade County the following, in the contract scope of services and/or upon request:

- An explanation of the training -- including RWP Basic Training, cultural sensitivity training, and other trainings as may be required by the RWP Recipient -- that has been and will be offered to Medical Case Managers, MCM Supervisors, and Peers. CQM trainings are not billable under MCM or PESN.

- 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 Haitian 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.

- As the Ryan White Program is the payer of last resort, clients who have Medicaid Managed Medical Assistance (MMA) or Long-Term Care (LTC) plans are not eligible to receive case management or referral services from the local Ryan White Part A/MAI Program. The MMA and LTC plans are contractually required to provide their clients with case management/care coordination.

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 In Network Referral process, which is available through the Provide® Enterprise Miami data management system. Referrals **cannot** be made for services not documented in the client's Action Plan (formally referred to as the Plan of Care; billing code to use remains POC – see below). However, in the case of emergency, an Action Plan 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 Provide® Enterprise Miami data management system. Referrals made to Part A/MAI services by non-Part A or non-MAI funded case managers will use the Out of Network (OON) 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.

All referrals from Medical Case Management services to Ryan White Part A Program Oral Health Care services should include the client's primary care or HIV physician's contact information (name, address, phone and fax numbers, and email if available) and note any known allergies the client may have. This information can be included in the comments section of the referral.

d) **Caseload.** Medical Case Managers should have an active caseload of no more than 70 clients.

e) **Peer schedules.** Providers are reminded that some Peers 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) **Health Assessments.** Medical Case Managers are expected to complete a Health Assessment annually for each client as may be amended via formal written notification from the Recipient (i.e., Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program). Updates to the Health Assessment should be conducted as needed during the year.

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 (i.e., 2 business days) after occurrence, unless the timeframe is suspended by the Miami-Dade County Office of Management and Budget during declared emergencies at the state or local level (e.g., during public health emergencies, hurricanes, etc.) or at the discretion of the County. Any Medical Case Management or Peer Education and Support Network encounter not properly recorded in the Provide® Enterprise Miami data management system within 48 hours (i.e., 2 business days) will be rejected in the system, unless the timeframe is suspended as noted above. When needed, 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 through the Provide® Enterprise Miami data management system. A reasonable justification for the delay in recording an encounter 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, or the Medical Case Management Supervisor to miss the 48-hour time limit for entering progress notes:

- An event beyond the Medical Case Manager, Peer, or Medical Case Management Supervisor's control, such as an illness, proven data system (e.g., Provide® Enterprise Miami

data management system or provider's electronic medical record data system) access issues, public health emergencies, or extreme weather events 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.

h) **Staff Training.** Medical Case Management staff (Medical Case Managers, Peers, and Medical Case Management Supervisors) must attend periodic training provided by the Ryan White Program's Clinical Quality Management and Training Program provided by BSR. In addition, effective April 7, 2017, any new Medical Case Managers, Peers, and Medical Case Management Supervisor hires under the Ryan White Part A or MAI Programs must complete all 13 of the Southeast AIDS Education and Training Center's (SE-AETC) web-based Medical Case Management and Cultural Competency curricula as required and as may be amended by the local Recipient **prior to** being approved for Provide® Enterprise Miami User Access. These curricula modules are indicated on the local Ryan White Program's AETC Training Module Checklist, and the modules can be accessed at the following website: https://www.seaetc.com/modules/. Time spent completing the SE-AETC training modules **cannot** be charged to the local Ryan White Part A/MAI Programs.

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 FY 2023~~3~~4 Service Delivery Manual for details, as may be amended.)

C. **Rules for Reimbursement:** The units of service used for Medical Case Management and PESN reimbursements are as follows. ***(IMPORTANT NOTE**: except for MCM and PESN (when referring to staff or service category), OMB, HIV/AIDS, and HIPAA, all acronyms used in this section are billing codes.)*

1. *Medical Case Management (MCM) Services* are reimbursed by unit cost, where one unit equals one minute of actual time, at rates not to exceed $1.15 per unit/minute. 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 $0.65 per unit/minute. See table below.

3. Providers are required to document each unit of service performed (including the type of encounter and length of time spent) as face-to-face encounters, tele-medical case management, plan of care, adherence counseling, or other activities conducted with or on behalf of a client. These units [i.e., service code(s) and time spent] shall be entered in the Provide® Enterprise Miami data management system when documenting each client's progress log and for billing purposes. Units of service must be documented and reported separately for PESN and Medical Case Management services.

4. Client eligibility screening for voucherable services (e.g., Medical Transportation vouchers) is billable as a unit of service depending on the amount of time spent with the client. Costs related to the ***actual distribution of voucher services*** should be covered under the dispensing charge allowed for handling of vouchers under the Medical Transportation service category (i.e., discounted transportation EASY Tickets or limited ride-share).

   Medical case management staff cannot use MCM encounter billing codes for time spent scheduling ride-share (e.g., Uber or Lyft) trips for a client with the ride-share transportation company. This activity is part of the dispensing fee allowable under the Medical Transportation service category if line items other than purchasing ride-share trips are included in the Medical Transportation budget.

   Adherence and care coordination efforts to secure the medical or social service (e.g., appointment with a provider) a client uses ride-share services to attend may be billed by Medical Case Management staff using the appropriate code (e.g., ADH, POC, COL, etc.) from the table directly below. In such cases, medical case management staff should take this opportunity to ask if the client was satisfied with the medical or social service appointment, if the client understood what was covered during the appointment, and if other care coordination or referral is needed as a result of the appointment.

5. No two Peers can bill for the same time and for the same client when specifically using the Face-to-Face (FFE) and Adherence (ADH) services codes.

6. The following table reflects MCM and PESN encounter/activity billing codes (in alphabetical order **by code**) that are active in FY 2023~~3~~4:

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Affordable Care Act (ACA) Health Insurance Marketplace	**ACA**	This code 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, communicating with American Exchange LLC on behalf of the client, 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 health insurance plan to client, how it works, what documents the client is required to present, as well as what benefits and restrictions the client has under the plan. Do NOT use this ACA code to record time spent actually enrolling a client on-line in an ACA Marketplace health insurance plan overseen by American Exchange or other third-party ACA enrollment agents. Time spent navigating or enrolling clients on line at www.healthcare.gov are not billable to the local Ryan White Program.
Adherence Counseling	**ADH**	This code includes adherence activities with the client such as medication counseling, risks and benefits of treatment, compliance with treatment regimen, education on medication resistance, compliance with medical and other core service appointments, and review of HIV case management portal information. Do NOT use this ADH code to record time spent by a medical provider (Physician, Advanced Practice Registered Nurse, Physician Assistant, etc.) providing adherence counseling, as this would be billed under the Outpatient/Ambulatory Health Services category. **UPDATE (12/8/2023): ALL medical case management interactions with clients should have an adherence counseling component (i.e., use of the ADH billing code with related progress log note). Case management without adherence counseling is not Ryan White Program Medical Case Management.**

Case Closure Activity	**CCA**	This code includes activities related to closing a client's case at the medical case management agency and in the Provide® Enterprise Miami data management system. The limit for this activity per client is 30 units (i.e., 30 minutes; see "Definition of a Unit" above).

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Collateral Contacts	**COL**	This code is to be used by Peers and Medical Case Management Assistants **only** to record communication with other care providers **inside** and **outside** of the Peer or Medical Case Management Assistant's own agency for **all** coordination of care activities conducted on behalf of the client. This includes telephone contacts or other electronic methods of communication (e.g., email or fax) with the outside or inside agency to obtain or provide additional information for the client's care. This code may also be used to document travel time with or on behalf of the client that is specific to care coordination, linkage to care, or retention in care activities conducted by Peer Educators or Medical Case Management Assistants. In such cases, documentation in the client chart must include reason for travel in relation to care coordination, linkage to care, or retention in care. This code **cannot** be used when pulling a chart to copy documents for a client's personal use or for filing documents. Instead, use the DOC billing code for pulling a chart or filing. Medical Case Managers and Medical Case Management Supervisors **cannot** use the COL code. Medical Case Managers and Medical Case Management Supervisors must use POC for **all** Plan of Care and coordination of care activities. See POC section below.
Consulting w/ Staff	**CON**	This code includes activities related to case consultation with internal staff. This code may **only** be billed by the agency's OMB-authorized Medical Case Management Supervisor or Lead Medical Case Manager.

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Documentation	**DOC**	This code includes activities related to documenting any encounter in the Provide® Enterprise Miami data management system, such as preparing the progress note to detail a face-to-face encounter, telephone contact, etc. This service code also includes time spent organizing the client record or filing, looking up, or pulling documents to make copies that are unrelated to coordination of care for the client. This code also includes conducting peer reviews of client charts. **Do <u>not</u> use this DOC code to record documentation of activities related to the client's care plan or preparing referrals. Instead use POC to record <u>any</u> Plan of Care activity conducted by the Medical Case Manager or Medical Case Management Supervisor.** **Supervisors should NOT use this DOC code when advised by Miami-Dade County's Ryan White Program staff as part of a billing or site visit review that a progress note needs to be reviewed, corrected and resubmitted.** **UPDATE (12/8/2023):** When recording documentation activities: • Any DOC encounter billed for **15 minutes or less** does NOT require an explanation in the progress log of the activity. • Any DOC encounter billed for **more than 15 minutes** requires a progress log note that indicates exactly which DOC activity was conducted (e.g., organizing the client record, scanning / copying documents to upload in PE Miami, documenting an encounter, entering the progress note in PE Miami, or copying records for the client's personal use for purposes unrelated to coordination of care.)

Adherence Encounter by Eligibility Specialist (with Bachelor's Degree)	**EDA**	This code is **only** for use by OMB-authorized Eligibility Specialists who have educational qualifications similar to a Ryan White Program Medical Case Manager (i.e., Bachelor's degree) (billable at $1.15 per minute). This code is to be used **only** by authorized persons when communicating the importance of treatment adherence to clients during a corresponding Eligibility Specialist encounter. **For treatment adherence activities conducted by Medical Case Managers, Peers, or Medical Case Management Supervisors, use the ADH code.**

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Eligibility Specialist (with Bachelor's Degree)	**EDE**	This code is **only** for use by OMB-authorized Eligibility Specialists who have educational qualifications similar to a Ryan White Program Medical Case Manager (i.e., Bachelor's degree) (billable at $1.15 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.
Adherence Encounter by Eligibility Specialist (no degree)	**ENA**	This code is **only** for use by OMB-authorized Eligibility Specialists who do not have a Bachelor's degree (billable at $0.65 per minute, similar to a peer or medical case management assistant). This code is to be used **only** by authorized persons when communicating the importance of treatment adherence to clients during a corresponding Eligibility Specialist encounter. **For treatment adherence activities conducted by Medical Case Managers, Peers, or Medical Case Management Supervisors, use the ADH code.**
Eligibility Specialist (no degree)	**ENE**	This code is **only** for use by OMB-authorized Eligibility Specialists who do NOT have educational qualifications similar to a Ryan White Program Medical Case Manager (i.e., no degree) (billable at $0.65 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.

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Face-to-Face Encounter	**FFE**	This encounter is defined as any time the Medical Case Manager, Peer Educator, or Medical Case Management 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. The FFE encounter 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. FFE may also be used to record travel time for the purpose of attending a medical appointment or social service appointment, only when traveling with the client. If travel is included in a FFE encounter, the appropriate reason and length of time must be documented in the client chart. A brief face-to-face encounter may be included with a POC activity to indicate that a client contact occurred on the same day as a POC activity. In such cases, a few minutes of the FFE code would be acceptable. This circumstance must be clearly explained in the progress notes.
Insurance Coordination and Retention	**ICR**	This code is **only** for use by OMB-authorized staff with special insurance coordinator roles (i.e., Users.IBM and Users.MCM.OpenNR) in the Provide® Enterprise Miami data management system. Approved activities include following up on health insurance policies to ensure clients are active or troubleshooting any issues where clients are dropped from an insurance policy, including where recoupment of funds may be needed (billable at $1.15 per minute).
Electronic Override Activity	**OVR**	This code may **only** be used by authorized Medical Case Management Supervisors or Lead Medical Case Managers. The limit for this activity per client is 30 units (i.e., 30 minutes; see "Definition of a Unit" above).

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Plan of Care (i.e., Action Plan)	**POC**	This code is **only** to be used by Medical Case Managers, Lead Medical Case Managers, and Medical Case Management Supervisors to record **all** Plan of Care activities (including initial development of the Plan of Care, ongoing updates, follow-up, communication with other providers **within** the Medical Case Manager, Lead Medical Case Manager, or Medical Case Management Supervisor's own agency **or with an outside agency** for coordination of care). This includes face-to-face encounters related to the Plan of Care, as well as phone conversations, emails, faxes, and related referrals. If a telephone conversation is specifically related to a Plan of Care activity, the POC code should be used. The TEL code should be used for general telephone contacts. Please see the FFE and TEL comments sections for additional POC-related guidance. Peer Educators and Medical Case Management Assistants are **NOT** authorized to create or update the Plan of Care; and, therefore, are restricted from using this POC code. **NOTE:** the Plan of Care is referred to as the Action Plan in the Provide® Enterprise Miami data management system.

Safety Backup (PESN only)	**PSFT**	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, a Peer/Peer Educator/Peer Navigator (Peer) may accompany the Outreach Worker; and the Peer should document the activity in the client chart, making note that they went to a high-risk area with an Outreach Worker and clearly stating that they went along as a safety back-up. The Peer should use the PSFT safety back-up code to record the entire service. Both the Peer and the Outreach Worker may reflect the time they spent on the encounter and have their agency or respective agencies report for the time and be reimbursed accordingly. The Peer **cannot** use any other encounter code or billing code for this activity on the same day.

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Chart Review	**REV**	This code 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-authorized Medical Case Management Supervisor or Lead Medical Case Manager.
Telephone Encounter	**TEL**	This code includes general 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. **IMPORTANT NOTE**: Telephone contacts with other care providers, for the purpose of coordinating care for clients, should be recorded as a collateral (COL) encounter if conducted by a Peer or Medical Case Management Assistant. Use the Plan of Care (POC) code if the telephone contact was done by a Medical Case Manager or the Medical Case Management Supervisor for the purpose of coordinating care. See COL and POC above for additional guidance. A brief general telephone encounter may be included with a POC activity to indicate that a client contact occurred on same day as a POC activity. In such cases, a few minutes of the TEL code would be acceptable. This circumstance must be clearly explained in the progress notes.
Tele-Medical Case Management (MCM)	**THM**	This code includes Tele-Medical Case Management services provided by Medical Case Manager, Medical Case Management Supervisor or Eligibility Specialist (with at least a Bachelor's degree). This is billable at $1.15 per minute.
Tele-Medical Case Management (PESN)	**THP**	This code includes Tele-Medical Case Management services provided by Peer, Medical Case Management Assistant, or Eligibility Specialist (with no degree). This is billable at $0.65 per minute.

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
RW-Approved Training	**TRN**	This code includes time spent at local Ryan White Program-approved training for Medical Case Managers, Peers/Peer Educators/Peer Navigators, Medical Case Management Supervisors, and Outreach Workers (using OTRN), such as quarterly case management supervisor trainings, County-approved Provide® Enterprise Miami data system trainings, and Ryan White Program Provider Forums. The TRN code may NOT be used to bill for any training that is NOT a Ryan White Program-specific 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 technical assistance provided by Behavioral Science Research Corporation (the Program's contracted clinical quality management provider), appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, SE-AETC on-line training modules, Linkage to Care Team meetings, or other employer-required training. Travel time or lunch (if time on your own) is NOT included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may NOT use the TRN code.

ADDITIONAL IMPORTANT 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 to 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 the wait time reaching a live person for assistance by telephone) and to make such reports available to OMB 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 if only one client, they will be required to adhere to the local Ryan White Program Service Delivery Manual, Medical Case Management Standards of Service, and Clinical 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 any person on a provider's staff supervises 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 Manual, Standards for Medical Case Management Supervisors, and Clinical 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.

MEDICAL TRANSPORTATION

(Year 3~~4~~43 Service Priorities: #13 for Part A and ~~#9~~ for MAI)

Medical Transportation is a support service. Medical Transportation is the provision of non-emergency transportation services that enables an eligible client to access or be retained in core medical and support services. Locally, this service is limited to specially-designated, discounted EASY Tickets (transportation vouchers) from the Miami-Dade County Department of Transportation and Public Works (DTPW; formerly Miami-Dade Transit Agency-MDTA) to program-eligible people with HIV attending medical and/or social service appointments. Daily, weekly and monthly discounted EASY Tickets are available when using the discounted EASY Tickets option. Alternative methods (such as ride-sharing services like Uber, UberHealth, Lyft, etc.) may be available, where requested by a Part A/MAI-funded subrecipient and approved by the Miami-Dade County Office of Management and Budget-Grants Coordination.

Providers of discounted EASY Tickets must demonstrate coordination with Miami-Dade County transportation agencies and services, Medicaid Special Transportation, Miami-Dade County 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 Agency's Transportation Disadvantaged Program (http://www.miamidade.gov/transit/transportation-disadvantaged-program-guidelines.asp) in order to obtain assistance for clients who are eligible under that program, where applicable. As a reminder, in all cases, the Ryan White Program must be used as the payer of last resort.

A. Program Operation Requirements: Discounted EASY Tickets are available to program-eligible clients who meet the requirements of this service category, for unlimited trips during the calendar month. These specially-designated EASY Tickets will not be usable in other months and are not "re-loadable."

These monthly transportation tickets should be distributed in a timely manner in order to maximize ticket usage. Unused discounted EASY Tickets (transportation vouchers) **cannot** be returned to the DTPW for credit. 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 and voucher availability. 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.

Multiple instances of reduced fare transportation assistance per client per month are **NOT** allowed regardless of circumstance, payer source, and/or government assistance program that is using/providing the subsidized fare. As payer of last resort, the Ryan White Program can only reimburse subrecipients (service providers) for EASY Ticket fares (vouchers) distributed to eligible clients that are **NOT ELIGIBLE** to receive subsidized transportation assistance or fares under **ANY OTHER** program. This restriction will be closely monitored by the County's DTPW and the Office of Management and Budget (OMB) as a condition of the Ryan White Program having program access to the discounted EASY Tickets. Lost or stolen EASY tickets **cannot** be replaced by the local Ryan White Part A Program and replacements will not be considered by DTPW.

Regular reconciliation through a secure data system match of clients receiving discounted EASY Tickets through the Ryan White Part A Program will be conducted on a quarterly basis between the County's authorized OMB and DTPW staff, to ensure clients are not receiving more than one (1) instance of reduced fare transportation assistance per month. Clients found to be receiving duplicative discounted transportation services may be banned from receiving any additional assistance from one or both sources (the County's Ryan White Program or DTPW). **Medical Case Managers and Medical Transportation subrecipients must inform clients of this restriction and the reconciliation process.**

Prior to distributing these transportation vouchers, **subrecipients of Medical Transportation services must ensure that clients**: 1) review and sign the "Miami-Dade County Ryan White Part A Program Acknowledgement to Receive Monthly Transportation Assistance" attesting to their understanding of this restriction, including consent for the reconciliation data system match; 2) indicate that they have not received other discounted transportation assistance for the same month; and 3) indicate that they do not qualify to receive free or subsidized transportation assistance (fare) from any other program. This client acknowledgement/consent form is required prior to the client receiving a discounted EASY Ticket **each month**. A copy of the acknowledgement for each month of service must be maintained in the client's record/chart at the Medical Transportation subrecipient's site.

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 at least one (1) monthly medical and/or social service appointments must be submitted by the client to the Medical Case Manager before the client can receive transportation assistance, unless otherwise directed by the

County. The number of required appointments is subject to change at the County's discretion with no less than thirty (30) days' written notice to all Part A/MAI-funded subrecipient agencies. Attendance at Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings also count towards the monthly appointment total. Any combination of medical, social service, AA, and/or NA appointments will count towards the required monthly total.

If allowable appointments are appropriately documented in the Client Profile in the Provide® Enterprise Miami data management system 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 grant 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 must be documented and service providers will 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.

IMPORTANT NOTE: Alternative methods of Medical Transportation service delivery are only available at select subrecipient agencies as a result of the corresponding Request for Proposals Process and subsequent contract negotiations.

B. **Rules for Reimbursement:** Discounted EASY Tickets cost $56.25 per monthly ticket (1-Month Pass), $14.60 per weekly ticket (7-Day Pass), and $2.80 per daily ticket (1-Day Pass); and these rates may be subject to change. The number of discounted EASY Tickets available for distribution should be consistent throughout the duration of the contract period, unless the cost of these EASY Tickets changes, and must take into consideration the total budget request, agency capacity, client eligibility, and demand for this service. Ride-share services will be reimbursed based on the cost of each one-way trip. Providers will be reimbursed based on properly documented service utilization reports from the Provide® Enterprise Miami data management system, indicating the date of discounted EASY Ticket distribution or ride-share trip, client CIS number, and dollar amount including dispensing charge. Dispensing charges, not to exceed 15% (or as may be adjusted by the County due to formula calculations on the budget form), 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. Discounted EASY Ticket orders, invoices, and payments, as well as monthly distribution logs and acknowledgement of program limitations signed by the client

and scanned into the Provide® Enterprise Miami data management system, or ride-share logs where applicable, will be reviewed.

The following billing codes shall be used:

- **TRANSPORTATION VOUCHERS FOR PUBLIC TRANSIT (DISCOUNTED EASY TICKETS)**
    - Service Name = "EASY Ticket – Monthly Pass" with Service Code = "**EASYM**"
        - A maximum of one (1) may be distributed per client per service month; no exception. **Lost, stolen or damaged tickets are not replaceable.**
    - Service Name = "EASY Ticket – Weekly Pass" with Service Code = "**EASYW**"
        - A maximum of three (3) weekly tickets may be distributed per client per service month. If another week is/was needed, a monthly pass should be used.
    - Service Name = "EASY Ticket – Daily Pass" with Service Code = "**EASYD**"
        - A maximum of four (4) daily tickets may be distributed per client per service month. If more days are/were needed, a weekly or monthly pass should be used.
- **RIDE-SHARE:**
    - Service Name – "Uber/Lyft Ride" with Service Code = "RIDE"
        - Uber/Lyft Ride – Home to Provider
        - Uber/Lyft Ride – Provider to Home
        - Uber/Lyft Ride – Provider to Provider
    - **IMPORTANT NOTES**:
        - In the Provide® Enterprise Miami data management system, a pop-up warning will appear if two of the same ride types are entered for the same day for a given client. The warning will suggest the user document the reason for the potential "duplicate" service in the Comments field to prevent the County from rejecting the service in the monthly payment request.

- Medical case management (MCM) staff cannot use MCM encounter billing codes for time spent scheduling ride-share (e.g., Uber, UberHealth, Lyft, etc.) trips for a client with the ride-share transportation company. This activity is part of the dispensing fee allowable under the Medical Transportation service category if line items other than purchasing ride-share trips are included in the Medical Transportation budget.

C. Additional Rules for Reporting: Providers must report monthly activity according to the type and dollar amount of the tickets issued, the number of tickets distributed, date of distribution per client, and the unduplicated number of clients served; or number of one-way ride share trips per client, where applicable. As stated above in Medical Transportation section A above, a reconciliation data system match will be conducted of all clients receiving discounted EASY Tickets through the Ryan White Part A Program. This reconciliation review will be conducted by the County's authorized Ryan White Program Recipient (OMB) and DTPW staff.

D. Special Client Eligibility Criteria: A Ryan White Program In Network Referral or an Out of Network Referral (a non-certified referral accompanied by all appropriate supporting documentation) is required for this service and must be updated annually, every 366 days. Clients receiving Ryan White Part A Program-funded Medical Transportation assistance must be documented as having gross household incomes below 400% of the 2023~~3~~4 Federal Poverty Level (FPL). Clients receiving discounted EASY Tickets (transportation vouchers) must be documented as having been properly screened for other public sector funding as appropriate annually, every 366 days. While clients qualify for and can access other public funding [including, but not limited to, Medicaid, Medicaid Managed Medical Assistance (MMA), or Medicaid Long-term Care (LTC) transportation services; or the County's Golden Passport program, Mobility EASY card program or Community-Reduced Fare program etc.) for transportation services], they will not be eligible for Ryan White Part A Program-funded Medical Transportation (discounted EASY Tickets or limited ride-share) assistance.

FOOD BANK
(Year 334 Service Priority: #75 for Part A)

Food Bank is a support service. The Food Bank program is a central distribution center providing actual food items (groceries), and personal hygiene products when available, for low income persons who are living with HIV or AIDS. Groceries are distributed in cartons or bags of assorted products to eligible Ryan White Program clients. Local 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. A referral to a Registered Dietitian under a Ryan White Program-funded Outpatient/Ambulatory Health Services provider (specialty care; a core medical service) may also be made for nutritional services to meet this requirement. Proof of the provision of nutrition services from the Food Bank provider, or a referral for nutrition services to an appropriate provider, or the client declining such service must be documented in the client's record.

Ryan White Program funds for Food Bank services may not be used for water filtration/purification systems in communities where issues of water safety do not exist, household appliances, pet foods, or other non-essential products.

A. Program Operation Requirements:

A.1 Standard Provisions

Food Bank services may be provided only on an **emergency basis**. For this program, 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 (or in the Client Profile in the Provide® Enterprise Miami data management system) 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 ongoing 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 and food distribution events.

Unless otherwise approved by the Miami-Dade County Office of Management and Budget, the provision of this service will be limited to twenty (20) occurrences within the Ryan White Part A Fiscal Year (March 1, 2023~~3~~4 through February 28, 2024~~3~~5). 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 five (5) months, or twice per month for ten (10) months, in the grant Fiscal Year or any variation thereof, with the limit of twenty (20) 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 $85.00 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 groceries on a **monthly** basis, the client will be limited to groceries valued at $85.00 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.

A.2. 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 twenty (20) 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 Program In Network 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 twenty (20) 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, 2023~~3~~4 through February 28, 2024~~3~~5) **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 or Licensed Nutritionist not associated with the Ryan White Part A Program-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 or Licensed Nutritionist must specify the frequency and number of additional Food Bank visits (occurrences) that should be allowed for the client (maximum of sixteen (16) additional occurrences).

A.3. Provision for Families

In addition to the maximum amount defined above for groceries available per week to eligible clients, each additional adult who is a person with HIV and lives in the same household is eligible to receive $85.00 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 a person with HIV) is also eligible to receive $26.00 per week in groceries, subject to the same service guidelines above. The client must provide documentation to prove the dependent's age and place of residence.

B. Rules for Reimbursement:

~~B.~~ 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 Miami-Dade County Office of Management and Budget-Grants Coordination (OMB-GC). The cost of the weekly bag of groceries will not exceed $85.00. 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:

~~C.~~ Providers must report monthly activities according to client visits (i.e., weekly occurrences). Providers must also submit to OMB 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:

~~D.~~ Providers must maintain documentation of the amount and use of funds for purchase of non-food items; and make this documentation available to OMB staff upon request.

E. Special Client Eligibility Criteria:

F. A Ryan White Program In Network Referral or an Out of Network Referral (accompanied by all appropriate supporting documentation) is required for this service; and must be entered in the Provide® Enterprise Miami data management system. 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 four (4) months. Providers must document that clients who receive Ryan White Part A Program- funded Food Bank services have gross household incomes that do not exceed 250~~400~~% of the 202~~3~~4 Federal Poverty Level (FPL).

~~E.~~ Clients who fall between 251% to 400% FPL should be referred to the Ryan White Part B Program to access Emergency Financial Assistance resources, as funding allows; or to other resources in the community.

Clients receiving Food Bank services must be documented as having been properly screened for Supplemental Nutrition Assistance Program (SNAP) (formerly known as the Food Stamp program) benefits, home-delivered meal services through Medicaid's Long-Term Care (LTC) program, other community food bank programs, 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 and as payer of last resort. 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 SNAP benefits when requesting Ryan White Program-funded Food Bank services, the client must submit a copy of their SNAP award/benefit letter as documentation that the award is $250.00 or less per month in nutrition assistance benefits per person in the household; unless otherwise adjusted by the Office of Management and Budget-Grants Coordination/Ryan White Program with written notification to subrecipients. If the client applied for Food Stamp benefits and was denied, a copy of the denial letter must be scanned into the Client Profile in the Provide® Enterprise Miami data management system.

While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Ryan White Part A Program-

---

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 Program-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).

ORAL HEALTH CARE

(Year 3~~3~~4 Service Priority: #~~6~~4 for Part A

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 Dentists, dental specialists, and Dental Hygienists, as well as licensed Dental Assistants. In accordance with Rule 64B5-9.011 of the Florida Administrative Code, Dental Assistants who are formally trained or have an appropriate certification (e.g., radiography) meet HRSA's definition of a licensed Dental Assistant.

This service may include diagnostic, preventive, and restorative services; endodontics, periodontics, and prosthodontics (removable and fixed); maxillofacial prosthetics; limited implant services (i.e., removal, repair, and placement [restricted for edentulous patients only] of implants); oral and maxillofacial surgery; and adjunctive general services as detailed and limited 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 $6,500 per Ryan White Part A Fiscal Year (March 1, 2023 through February 29, 2024). Exceptions to the annual cap may be approved by the County under special circumstances (e.g. implant placement) and the provision of preventive Oral Health Care services with consultation from the Miami- Dade HIV/AIDS Partnership's Medical Care Subcommittee as needed.~~

A.

When a referral from a Dentist to a dietitian is needed, the Dentist must coordinate with the client's ~~Primary Care Physician~~Licensed Medical Provider 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.

Labs maybe requested ~~of~~ from Licensed Medical Providers~~physicians~~ as clinically indicated by the dentist.

All referrals to Ryan White Part A Oral Health Care services should include the client's primary care or HIV Physician's contact information (name, address, phone and fax numbers, and email if available) and note any known allergies the client may have. This information can be included in the comments section of the referral.

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).

Teledentistry services may also be available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details.

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 FY 2023~~3~~4 Service Delivery Manual for details.) Providers will be required to demonstrate that they adhere to generally accepted clinical guidelines for Oral Health Care treatment of HIV and AIDS-specific illnesses, upon request and through monitoring site visits or quality management record reviews.

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, local Ryan White Program Oral Health Care Formulary using the 2023~~3~~4 American Dental Association Current Dental Terminology (CDT 2023~~3~~4) codes for dental procedures. Reimbursement is in accordance with the rates indicated in the most current, local Ryan White Program Oral Health Care Formulary; flat fee, no multiplier.

Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details regarding the reimbursement of teledentistry services.

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

D. Children's Eligibility Criteria: Providers must document that children with HIV who receive Ryan White Part A Program-funded Oral Health Care services are permanent residents of Miami-Dade County and have been properly screened for other private or public sector funding [i.e., private insurance, Medicaid, Medicaid's expanded dental insurance for its members with Managed Medical Assistance (MMA) or Long-Term Care (LTC) coverage who have LIBERTY Dental, DentaQuest, or MCNA Dental benefits (as may be amended), the Medically Needy Program, Children's Health Insurance Program (CHIP), Florida KidCare, etc.)], as appropriate. While children qualify for and can access private insurance, Medicaid (all programs), or other public sector funding for Oral Health Care services, they will not be eligible for Ryan White Part A Program-funded Oral Health Care services, except those dental procedures excluded by the other funding sources.

E. **Client Eligibility Criteria:** Clients receiving Oral Health Care must be documented as having been properly screened for other public sector funding as appropriate every 366 days. While clients qualify for and can access dental services through other public funding [including, but not limited to, Medicaid, Medicaid Managed Medical Assistance (MMA), or Medicaid Long-Term Care (LTC)], Medicare, or private health insurance, they will not be eligible for Ryan White Part A Program-funded Oral Health Care except for such program-allowable services that are not covered by the other sources or if their related benefits have been maxed out for the benefit period.

Clients referred for Oral Health Care by a Ryan White Part A or MAI Medical Case Manager should use the Ryan White Program In Network Referral process in the Provide® Enterprise Miami data management system. If the client is referred by a non-Part A or non-MAI provider ["Out of Network"(OON) provider] or self-refers because they do not have a Part A/MAI Medical Case Manager, an OON 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 documentation to support Ryan White Part A Program eligibility and Viral Load and CD4 lab test results within 366 days, are also able to access Ryan White Part A Oral Health Care services, upon completion of a brief intake in the Provide® Enterprise Miami data management system by the Oral Health Care provider agency and the client's signed consent for service

F. **Ryan White Program Oral Health Care Formulary:** Ryan White Part A Program 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.

G. **Letters of Medical Necessity**: Dental Implants require a completed Ryan White Letter of Medical Necessity (LOMN) (See Section V of this FY 2024 Service Delivery Manual for copies of the Letter of Medical Necessity, as may be ammended).

~~G.~~H. **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, licensure documents, and proof of training, where applicable, of the dental staff providing services to Ryan White Program clients. Providers must make these documents available to OMB staff or authorized persons upon request.

~~H.~~I. **Rules for Reporting:** Provider monthly reports (i.e., reimbursement requests) 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 staff or authorized persons upon request.

SUBSTANCE ABUSE OUTPATIENT CARE AND SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

(Year 3~~3~~4 Service Priorities: #8~~12~~ for outpatient Part A and #8~~6~~ for MAI; and #7~~10~~ for Part A residential only)

Two types of substance abuse counseling and treatment services are included in this section: Outpatient and Residential. **Substance Abuse Outpatient Care** is a core medical service. **Substance Abuse Services (Residential)** is a support service. Both of these substance abuse service components 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 people with HIV 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-determination, dignity, responsibility for own actions, relief of anxiety, and peer support.

Providers are encouraged to offer program services to families to support the family unit. However, substance abuse services may be provided to members of a client's family in an outpatient setting only (i.e., non-HIV family members may not stay in the residential facility), and only if the program-eligible individual served (client) is also being served. 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). ***IMPORTANT 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 services must offer flexible schedules that accommodate the client's nutritional needs in order to facilitate client compliance with medication regimens.

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

A residential substance abuse episode is not a pre-requisite to access Substance Abuse Outpatient Care. However, clients stepping down from or completing Substance Abuse Services (Residential) are encouraged to transition to Substance Abuse Outpatient Care. Furthermore, providers shall attempt a warm hand off to Substance Abuse Outpatient Care, where appropriate.,

I. Substance Abuse Outpatient Care

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. This service includes 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~~ Licensed Medical Provider 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.

Services include screening, assessment, diagnosis and/or treatment of substance use disorder. Allowable substance use disorder treatments include: pre-treatment/ recovery readiness programs; harm reduction; behavioral health counseling associated with substance use disorders; outpatient drug-free treatment and counseling; medication assisted therapy; psychopharmaceutical interventions; substance abuse education; and relapse prevention. Services may also include mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; conflict resolution; anger management; and relapse prevention. All clients receiving this service must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis of substance use disorder.

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the Ryan White HIV/AIDS Program, it is included in a documented plan. Acupuncture therapy must be provided by an acupuncturist who is licensed in the State of Florida to provide such service.

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) total persons per group. The ratio of group counseling

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 Outpatient Care levels are specific to the education level of

the provider of the service, as indicated below, and are not interchangeable:

- **Substance Abuse Outpatient Care (Level I) - Professional Substance Abuse Counseling.** Level I services include *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 a *doctorate or postgraduate degree* (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 Outpatient Care (Level II) - Counseling and Support Services.** Level II services include 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.

- **Tele-substance abuse outpatient care services** are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

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 FY 202~~3~~4 Service Delivery Manual for details, as may be amended.)

C. Rules for Reimbursement: Reimbursement for individual and group Substance Abuse Outpatient Care will be based on half-hour counseling sessions (i.e., 1 unit) 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 counseling, whereas, reimbursement for group sessions is calculated for the Counselor that provided the group counseling. Documentation activities are included in the Substance Abuse Outpatient

Care unit of service and are not to be billed as a separate encounter. Substance Abuse Outpatient Care may be provided to members of a client's family in an outpatient setting if the program-eligible person with HIV (client) is also being served. The 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.

Tele-substance abuse outpatient care services are reimbursed as follows:

New Code	Description	Flat rate Reimbursement
THSAC1	Tele-Substance Abuse Outpatient Care provided by a Level I provider (individual client only)	$30.00 per 30-minute session
THSAC2	Tele-Substance Abuse Outpatient Care provided by a Level II provider (individual client only)	$27.00 per 30-minute session

D. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group counseling 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 Substance Abuse Outpatient Care 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, Medical Case Manager, and Licensed Primary Care ~~Physician~~ Provider 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.

IMPORTANT NOTE: referrals from residential substance abuse services to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility, or once the client has completed or left their residential treatment program.

F. **Additional Rules for Documentation:** Providers must submit an assurance to OMB that Substance Abuse Outpatient Care 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 staff or authorized persons upon request. Providers must also submit to OMB 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 local 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 Services (Residential)

This program offers substance abuse, including alcohol addiction and/or addiction to legal and illegal drugs, treatment and counseling, including HIV specific counseling, to program-eligible people with HIV (clients) on a short-term basis. Medication-Assisted Treatment (MAT) is also covered as part of the residential treatment services. **Substance Abuse Services (Residential)** provides room and board, in a secure, drug-free, state-licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Detoxification services are allowable, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital). HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license. Proof of the separate license is required for detoxification services.

In accordance with HRSA Policy Clarification Notice #16-02, Substance Abuse Services (Residential), as part of a substance use disorder treatment program funded under the Ryan White HIV/AIDS Program, are permitted **only** when the client has received a written referral from a clinical provider. In Miami-Dade County's Ryan White Part A/MAI Program, this requirement shall be met if the client is accessing the service based on a Ryan White Program In Network Service Referral or Out of Network Referral as a result of a comprehensive health assessment conducted by a Medical Case Manager or other case manager or in response to a court-ordered directive to a residential treatment program. Upon arrival at the residential treatment center and PRIOR TO final enrollment in the treatment program, an assessment MUST be conducted by the residential clinical staff (e.g., Medical Director, Psychologist, Licensed Therapist, etc.) as appropriate using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) assessment

tool (e.g., ASAM Criteria®, a Level of Care determination tool) for diagnosis of a substance use disorder or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) tools. Services will then be 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 the residential facility 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.B. 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 Services (Residential) is a *client-day* of care up to a maximum amount of $250.00 per day. The final, maximum rate is negotiated between the County's Office of Management and Budget-Grants Coordination division and each funded subrecipient. **Under normal circumstances clients may not be enrolled in any Ryan White Program-funded Substance Abuse Services (Residential) program for longer than 180 calendar 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, unless approved by the Miami-Dade County Office of Management and Budget for extreme circumstances (e.g., public health emergencies such as COVID-19 or extreme weather events such as hurricanes). Override requests may be considered on a case-by-case basis and would be approved or denied at the discretion of Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program (OMB-GC/RWP) management. Please contact the OMB-GC/RWP office for pre-approval prior to extending residential care past the 180-day cap. The length of stay for existing clients will be closely monitored by the County's OMB/Ryan White Program.**

Residential substance abuse treatment providers are strongly encouraged to check the Provide® Enterprise Miami data management system 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 180-day/12-month period. In addition, providers should call or email the client's previous Substance Abuse Services (Residential) provider, if applicable, to inquire if any services are pending to be entered or compiled in the Provide Enterprise® Miami data management system. This will affect the actual number of available days versus those that appear in the Provide® Enterprise Miami data management system.

C. **Additional Rules for Reporting:** Monthly activity reporting (i.e., reimbursement requests) for Substance Abuse Services (Residential) is per *client-day* of care and number of unduplicated clients served. Providers will indicate in the Provide® Enterprise Miami data management system the client's disposition after Substance Abuse Services (Residential) has ended (e.g., treatment completed, client referred to outpatient substance abuse counseling, client withdrew from treatment, etc.). This process is facilitated by the review and managing of the "RSA Disenrollment Report" available in the Provide® Enterprise Miami data management system. Service providers are required to print this report on a monthly basis and disenroll clients who are no longer in active care. Once all residential treatment disenrollments for the month are completed, a final "RSA Disenrollment Report" must be printed and uploaded along with the monthly reimbursement request that is uploaded in the Provide® Enterprise Miami data management system.

D. **Linkage/Referrals:** Providers of Substance Abuse Services (Residential) 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, Medical Case Manager, and the Licensed Primary Care Provider~~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 Provide® Enterprise Miami data management system upon the client's discontinuance or release from, completion of, and/or relapse in residential substance abuse treatment.**

IMPORTANT NOTE: referrals from residential substance abuse services to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility, or once the client has completed or left their residential treatment program.

E. **Special Client Eligibility Criteria:** A Ryan White Program In Network Service Referral or an Out of Network Referral (accompanied by all appropriate supporting documentation) is required for this service. Clients receiving Ryan White Program Part A or MAI-funded Substance Abuse Services (Residential) must be documented as having gross household incomes below 400% of the 202~~3~~4 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 staff or authorized persons upon request. Providers must submit to OMB 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.

III. Additional Standards and Guidelines

Guidelines: Outpatient and residential substance abuse treatment and counseling providers will adhere to generally accepted clinical guidelines for substance abuse treatment of people with HIV. The following are examples of such guidelines:

- American Society of Addiction Medicine. *The ASAM Principles of Addiction Medicine,* Sixth Edition; November 2, 2018.
  Available at: https://www.asam.org/publications-resources/textbooks
  Accessed 16/2~~0~~5/2022~~3~~4.

- American Society of Addiction Medicine (ASAM). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* Fourth~~Third~~ Edition.
  Available at: https://www.asam.org/publications-resources/textbooks
  Accessed 16/2~~0~~5/2022~~3~~4. ~~(Note: the Fourth Edition is currently in development.)~~

- American Society of Addiction Medicine. Current and archived public policy statements related to the treatment of substance use disorder.
  Available at: https://www.asam.org/advocacy/public-policy-statements
  Accessed 16/2~~0~~5/2022~~3~~4.

- Rules governing the treatment of physically drug dependent newborns, substance exposed children, and/or children adversely affected by alcohol and the families of these children that are consistent with the administrative regulations promulgated in Chapter 65 of the Florida Administrative Code by the State of Florida Department of Children and Family Services, as may be amended.

- Rules governing the provision of substance abuse treatment services consistent with the regulations promulgated by the State of Florida's Alcohol Prevention and Treatment (APT) and Drug Abuse Treatment and Prevention (DATAP) programs, as may be amended.

- Rules governing the provision of residential and outpatient substance abuse treatment services with regards to licensure and regulatory standards that are consistent with the administrative regulations promulgated in Chapter 65D-30, Substance Abuse Services Office, of the Florida Administrative Code under the State of Florida Department of Children and Families, as may be amended.

IV. **Best Practices Compilation Search** provides interventions that improved outcomes: https://targethiv.org/bestpractices/search?keywords=substance%20abuse&page=1

EMERGENCY FINANCIAL ASSISTANCE

(Year TBA Service Priorities: #TBA for Part A and MAI)

Emergency Financial Assistance is a support service. Under the local Ryan White Part A and MAI Programs, Emergency Financial Assistance provides **three** components: limited, short-term medications to support Test and Treat Rapid Access (TTRA), electric utility assistance, and rental/emergency rental assistance. Funding under this service category is **limited**.

Services are intended to assist clients with an urgent need such as the primary household provider's loss of employment, loss of income, or a natural disaster within one of the previously mentioned components required to improve health outcomes that are associated with other approved service categories, excluding clients accessing Test and Treat Rapid Access (TTRA) Medications who do not need to meet the urgent need criteria. All Emergency Financial Assistance ***must*** occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are ***not*** permitted.

A. Test and Treat Rapid Access (TTRA) Medications

Limited one-time or short- term vision of approved formulary HIV/AIDS-related medications only, either directly or through a voucher program, while a client's eligibility for medication assistance is pending with a third-party payer. Subrecipients must be a Ryan White Part A or MAI Program-funded subrecipient also receiving AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program) funding and must have a current Public Health Service 340B certification from the federal Office of Pharmacy Affairs. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Ryan White Part A or MAI Program funds for these purposes will be as the payer of last resort, and for limited amounts, use and periods of time.

Currently, these funds are limited to the provision of short-term access to antiretroviral medications (ARV) for clients participating in the Test and Treat / Rapid Access (TTRA) protocol. In such instances, these services would only be used when the Florida Department of Health's financial resources for ARV medications under the local TTRA protocol have been depleted and the client is not yet enrolled in ADAP Emergency Financial Assistance.

Medications in the TTRA protocol, as may be amended based on guidance from the Florida Department of Health in Miami-Dade County, include:

- Biktarvy®
- Descovy® + Prezcobix®
- Dovato®

- Symtuza®
- Tivicay® + Descovy®

Medications in the TTRA protocol for women of childbearing potential (or for women presenting with pregnancy potential on inadequate contraception), as may be amended based on guidance from the Florida Department of Health in Miami-Dade County, include:

- Tivicay® + Truvada®
- Tivicay® + Descovy®
- Prezista® + Norvir®

IMPORTANT NOTES:

1) Tivicay® (dolutegravir) replaced Isentress® as a regimen appropriate and recommended for women at all stages of pregnancy – conception to birth. Tivicay® may be used with either Truvada® or Descovy®. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission (the Panel) recommends dolutegravir (DTG) as a Preferred antiretroviral (ARV) drug throughout pregnancy and now also recommends DTG as a Preferred ARV for women who are trying to conceive. (2/10/2021)

2) Dovato® (dolutegravir/lamivudine) has clinical data on use in the Test and Treat scenario (STAT clinical trial). Dovato® samples or vouchers can be obtained from ViiV Healthcare pharmaceutical representatives for use in subrecipient clinic(s). As such, the Florida Department of Health cannot be invoiced for this medication.

3) Symtuza®; subrecipients / service providers may prescribe this medication, but they must use the voucher provided by Janssen Pharmaceuticals to cover the cost of this medication. As such, the Florida Department of Health cannot be invoiced for this medication.

Should the need arise to implement this service category (i.e., when Florida Department of Health's TTRA medication funds are depleted), the funds available under this service category may increase through the Reallocations/Sweeps process. Furthermore, if this service category is implemented, the rules under AIDS Pharmaceutical Assistance (Local AIDS Pharmaceutical Assistance Program) apply, except for the allowable medications which are limited to the most current, locally-approved medications for the TTRA protocol.

A.1. Eligibility

Only clients whose gross household income is at or below 400% of the Federal Poverty Level and have a pending application with a third-party payer (e.g., ADAP or private insurance) are eligible for Test and Treat Rapid Access (TTRA) Medications.

B. Electric Utility Assistance

Provision of this service to any single client is **limited to $200 in a fiscal year**. All reasonable attempts will be made to utilize any other programs, e.g. Federal Emergency Management Agency (FEMA) or Low-Income Home Energy Assistance Program (LIHEAP).

B.1. Eligibility

Only clients whose gross household income is at or below 250% of the Federal Poverty Level are eligible for Electric Utility Assistance.

C. Rental/Emergency Rental Assistance

Provision of this service to any single client is **limited to up to $3,000 in a fiscal year**. All reasonable attempts will be made to utilize any other programs e.g., Federal Emergency Management Agency (FEMA).

C.1. Eligibility

Only clients whose gross household income is at or below 250% of the Federal Poverty Level are eligible for Rental/Emergency Rental Assistance.

New Services Definition Development *Attachment #14*		
#	**Motion**	**Details**
15	**Motion to accept the Emergency Financial Assistance Service Definition for the next Ryan White Program Part A/MAI RFP as presented.** ▪ *Attachment #14*	Last year a directive was issued requesting five services be added to the next Ryan White Program Part A/MAI Request for Proposals (RFP). Emergency Financial Assistance, while already a prioritized service, was expanded to include two additional components. Look for the highlighted areas for new language in the document.
16	**Motion to remove Health Education/Risk Reduction from the service categories in the next Ryan White Program Part A/MAI RFP.**	Upon review PCN #16-02 and discussion of other services that already provide or can provide the Health Education/Risk Reduction, the Committee decided not to include the item as a stand-alone service for the next RFP.

COMMUNITY COALITION ROUNDTABLE – JANUARY 29, 2024 AND FEBRUARY 26, 2024
1 MOTION

- January: Members participated in a ViiV Healthcare training, "Diary of a Virus". Future meetings will focus on recruitment strategies in collaboration with the Florida Department of Health's Speaker's Bureau.

- February: Members and guests participated in an interactive presentation about the Partnership, "We All Have a Role to Play!" Member reviewed the new Partnership member application for Kai Chassi.

New Member Applicant		
#	**Motion**	**Details**
17	**Motion to recommend to the Mayor of Miami-Dade County the appointment of Kevin "Kai" Chassi for a *Representatives of the Affected Community* seat on the Miami-Dade HIV/AIDS Partnership.**	Members reviewed the application of David "Kai" Chassi to serve on the Partnership as a Representative of the Affected Community. Kai has completed the online interest form; a personal interview with staff and Community Coalition Chair, Lamar McMullen; a Community Coalition Roundtable member interview; and all required application paperwork. We are pleased to present his application for the Partnership's consideration.

STRATEGIC PLANNING COMMITTEE – MARCH 8, 2024
1 MOTION

Members:

- Elected Dr. Diana Sheehan as Chair and Angela Machado as Vice Chair.
- Approved Karen Poblete as a new member.
- Reviewed their 2024 Agenda Topics.
- Completed a thorough review of the Report of Findings and Follow Up Recommendations from the 2023 Assessment of the Recipient Administrative Mechanism Surveys.
  - Several procedural improvements were suggested, including using the back of meeting agendas to include meeting terminology; updating the Housekeeping presentation to encourage participation; hold post-meeting debriefing sessions; and make RSVP follow up calls to new members and meeting guests. Staff has begun implementing these changes and will report back on their progress.
  - The review resulted in an action plan for following up on the findings. The assessment is an annual HRSA requirement. Members would like guidance from HRSA regarding the requirement, and put forth a motion to direct staff, as noted below.

Directive to Staff

#	Motion	Details
18	**Motion for BSR staff to request guidance from our HRSA Project Officer to assess implementing a two-year AAM cycle to allow for survey administration one year and implementation of changes based on the results in the next year.**	In previous years, the Assessment of the Recipient Administrative Mechanism survey results have been compiled and reported to HRSA, after which the next survey cycle begins without any time for following up on the results. Members noted there are only incremental changes over time in most survey responses so an annual survey may not be merited. A two-year cycle would allow the committee to administer surveys in year one and implements changes in year two. On that cycle, the year one report would be survey findings, and the year two report would be implementation results.

OTHER COMMITTEES

Executive Committee – January 30, 2024 and February 28, 2024

- January: Members met with Health Resources and Services Administration (HRSA) staff as part of the HRSA Ryan White Program site visit.
- February: Members discussed and reviewed the Planning Council Support Scope of Work; discussed, reviewed, and approved the Planning Council Support Budget; approved time sensitive motions on revised Nutritional Assessment Letter for Extension of Food Bank Services and Miami-Dade Ryan White Program Service Standard Excerpts based on PCN #16-02 for FY 2023 and 2024; and discussed 2024 planning.

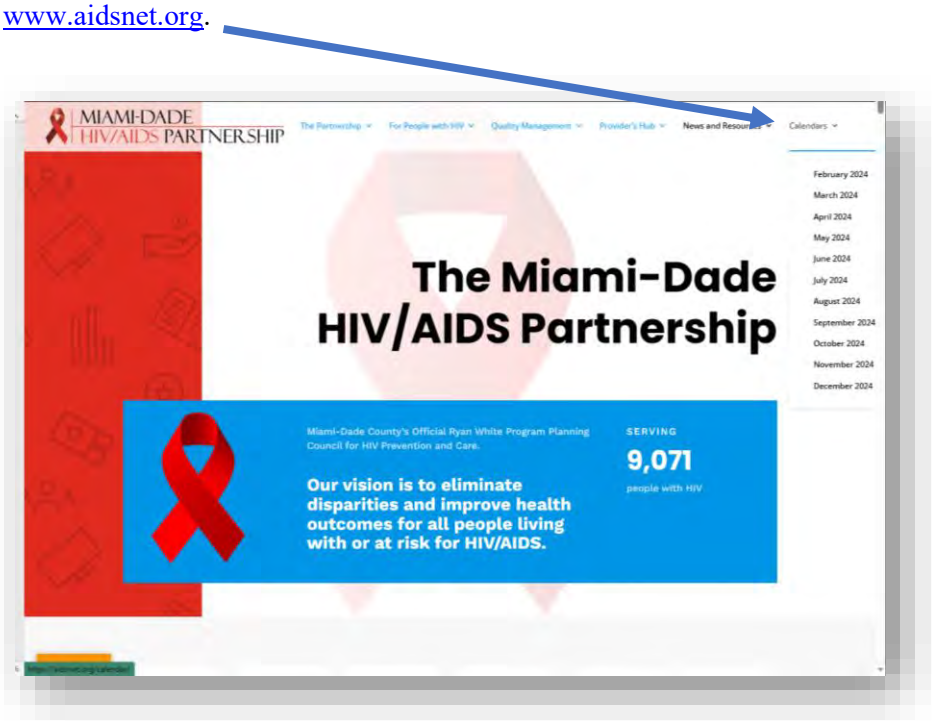
Housing Committee – February 15, 2024
Members re-elected Stephen Herz as Chair; continued to work on the Housing Stakeholder meeting planning; and discussed future meeting locations.

Prevention Committee
This committee has not held a stand-alone meeting since the last Partnership meeting.

Joint Integrated Plan Review Team – February 13, 2024
Members reviewed the first sets of data in the new VMSG Integrated Plan database and reviewed Integrated Plan Evaluation Workgroup recommendations.

NEXT MEETING

The next meeting date is TBA. Following the outcome of today's meeting, the calendar will be updated and posted at www.aidsnet.org.



Members!
Please PSVP; review materials in advance as posted online; and attend your scheduled meetings.

Contact staff at mdcpartnership@behavioralscience.com for more information.

APPROVAL OF REPORTS
1 MOTION

Approval of Reports	
#	**Motion**
19	**Motion to accept the Membership, Grantee/Recipient, and Committee Reports as presented.**