Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

AGENDA

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II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 11, 2024	All
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	• Service Definition Review: Outreach and Health Insurance	All
	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Mary Jo Trepka

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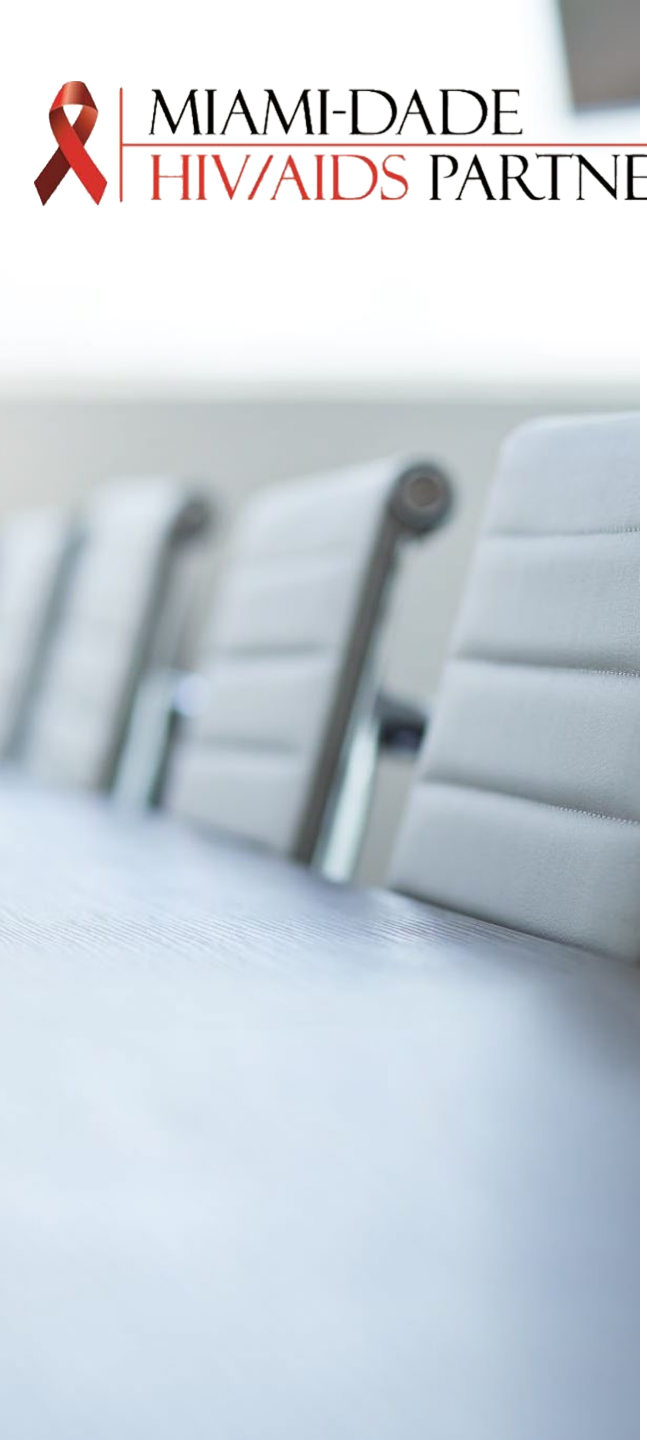
MIAMI-DADE HIV/AIDS PARTNERSHIP



Meeting Housekeeping- Care and Treatment

Updated January 8, 2024

Behavioral Science Research

Disclaimer & Code of Conduct

- Audio of this meeting is being recorded and will become part of the public record.
- Members serve the interest of the Miami-Dade HIV/AIDS community as a whole.
- Members do not serve private or personal interests, and shall endeavor to treat all persons, issues and business in a fair and equitable manner.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.

Language Matters!

In today's world, there are many words that can be stigmatizing. Here are a few suggestions for better communication.

Remember **People First** Language . . .
People with HIV, ***People*** with substance use disorders, ***People*** who are homeless, etc.

Please don't say **RISKS** . . . Instead, say **REASONS.**
Please don't say, **INFECTED with HIV** . . . Instead, say **ACQUIRED HIV, DIAGNOSED with HIV,** or **CONTRACTED HIV.**

Please **do not** use these terms . . .

Dirty . . . Clean . . . Full-blown AIDS . . . Victim . . .

General Housekeeping

- You must sign in to be counted as present.
- Place cell phones on mute or vibrate - *If you must take a call, please excuse yourself from the meeting.*
- Eligible committee members should see staff for a voucher at the end of the meeting

Meeting Participation

- Raise your hand if you need clarification about any terminology or acronyms used throughout the meeting.
- Raise your hand to be recognized by the Chair or added to the queue.
- Discussion should be limited to the current Agenda topic or motion.
- Speakers should not repeat points previously addressed.
- Any attendee may be permitted to address the board as time allows and at the discretion of the Chair.

Resources

- Behavioral Science Research Corp. (BSR) staff are the Resource Persons for this meeting.
- See staff after the meeting if you are interested in membership or if you have a question that wasn't covered during the meeting.
- Today's presentation and supporting documents are online at https://aidsnet.org/the-partnership/ and select your meeting.

Meeting Materials Access-Main Page

Main Page-Selection

Care and Treatment-Main

Care and Treatment Committee

Next Meeting: January 11, 2024 at 10:00 a.m.

Behavioral Science Research Corporation, 2121 Ponce de Leon Boulevard, Suite 240, Coral Gables, FL 33134

AGENDA

January 11, 2024

MINUTES

December 14, 2023

PARTNERSHIP REPORT

Report of approved motions
December 18, 2023

RETURN TO MENU

MEETING DOCUMENTS

- Care and Treatment Committee Service Definitions Development
- Service Delivery Standards: Other Professional Services (Legal Services and Permanency Planning)
- Service Delivery Standards: Food Bank
- Nutritional Assessment Letter for Food Bank Services
- Service Delivery Standards: Emergency Financial Assistance
- Service Delivery Standards: Medical Case Management
- Service Delivery Standards: Medical Transportation
- 2024 Officer Nominations and Elections

JOIN THE COMMITTEE!

Click here.
People with HIV may be eligible for vouchers!

RSVP OR CONTACT US

Marlen Meizoso
marlen@behavioralscience.com
(305) 445-1076

BYLAWS

Click here.

Care and Treatment- Additional Reports

Partnership, Recipient, and Grantee Reports

Members are asked to review reports in advance of meetings.
For questions or to request a paper copy of any report(s), please contact hiv-aidsinfo@behavioralscience.com.

PARTNERSHIP REPORTS

- Top Line Summaries Report (December 18, 2023)
- Partnership Report to Committees (December 18, 2023)
- Vacancy Report (November 9, 2023)

RECIPIENT AND GRANTEE REPORTS

- Top Line Summaries Report (December 18, 2023)
- Ryan White Program Part A / MAI – Expenditures (November 29, 2023)
- Ryan White Program Part A / MAI – Utilization & Service Definitions (September 2023)
- Ryan White Part B (October 2023)
- General Revenue (October 2023)
- AIDS Drug Assistance Program (ADAP) (November 2023)

YEAR END REPORTS

- Ryan White Program Part A / MAI Monthly and Year-To-Date Service Utilization Summary with service unit definitions (End of FY2022)
- Ryan White Program Part A / Minority AIDS Initiative (MAI) FY2022 Expenditures Report (End of FY 2022)
- Year 2022-2023 Ryan White Program Part B Report (Final)

SPECIAL REPORTS AND PROGRAM UPDATES

Care and Treatment- Functions and Historical Docs

Dr. Diego Shmuels

Chair

Dr. Mary Jo Trepka

Vice Chair

What We Do

- Develops and implements care and treatment planning.
- Conducts an annual comprehensive Annual HIV/AIDS Needs Assessment.
- Determines Ryan White Program (Part A/MAI) service priorities.
- Allocates Ryan White Program (Part A/MAI) funds each fiscal year.
- Develops directives based on identified access issues to underserved populations and areas of greatest need.
- Evaluates service cost and utilization of Partnership programs as a whole.
- Identifies funding and provider resources within Miami-Dade County.
- Makes recommended appointments to the Florida Comprehensive Planning Network's (FCPN) Patient Care Planning Group (PCPG).

Past Meetings

RETURN TO MENU

Agendas | Minutes | Meeting Documents

Care and Treatment- Needs Assessment Materials

Annual HIV/AIDS Needs Assessment

Decisions made during Needs Assessment drive the provision of services and distribution of funds for the next Ryan White Program fiscal year. All Partnership and committee members, Ryan White Program clients and other people with HIV, Ryan White Program subrecipients, and anyone interested in maximizing resources and improving services for people with HIV in Miami-Dade County are encouraged to participate in this and all Partnership activities.

2023 Needs Assessment

- Complete Needs Assessment Book (September 14, 2023; 489 pages)
  - Process for Setting Priorities and Allocating Resources
  - Needs Assessment Responsibilities
  - 2023 Guide to Dashboard Cards
  - Updated Dashboard Cards
  - Policy Clarification Notice (PCN) #16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds
  - Using MAI Funds Effectively: Tailoring Services for Locally Identified Subpopulations
  - Community Input: Integrated Plan Development & Virtual Town Hall
  - Ryan White Program 2022 Client Satisfaction Survey Summary of Findings
  - Unmet Needs Presentation
  - Co-Occurring Conditions Presentation
  - Other Funding Sources PPT
  - Service Utilization Data PPT (revised)
  - Age, Gender, Utilization Report
  - Miami-Dade Medicaid Expenditures
  - Miami-Dade Medicaid Demographics
  - Ryan White Program Demographic Data FY 2022
  - Ryan White Program HIV Care Continuum Fiscal Year 2022
  - Early Identification of Individuals with HIV/AIDS
  - Summary of HIV Epidemiology Profile Data 2020-2021 (revised)

Care and Treatment- RSVPs

RSVP!

Your RSVP Matters!

JOIN THE PARTNERSHIP!

We use RSVPs to determine if there will be a quorum of members and to make sure we have enough materials for all attendees. Please click a link below to let us know which meetings you can or cannot attend. All replies are helpful!

Meeting dates and locations are subject to change. For details, please see the latest meeting calendars at aidsnet.org/calendar.

Thank you for your time.

- January 2024
- February 2024
- March 2024
- April 2024
- May 2024
- June 2024
- July 2024
- August 2024
- September 2024
- October 2024
- November 2024
- December 2024

RETURN TO MENU

Scan to access meeting documents.

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Floor Open to the Public

“Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.

“BSR has a dedicated line for statements to be read into the record. No statements were received.”

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment Committee Meeting
Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134
January 11, 2024 Minutes

#	Committee Members	Present	Absent
1	Henriquez, Maria	X	
2	Mills, Vanessa		X
3	Siclari, Rick		X
4	Shmuels, Daniel	X	
5	Shmuels, Diego	X	
6	Trepka, Mary Jo	X	
7	Wall, Dan	X	
Quorum: 3			

Guests	
Fils Aime, Louvens	
Julme, Henry, MD	
Poblete, Karen	
Staff	
Marlen Meizoso	Robert Ladner

All documents referenced in these minutes were accessible to members and the public prior to (and during) the meeting, at www.aidsnet.org/meeting-documents.

I. Call to Order

Dr. Mary Jo Trepka

Dr. Mary Jo Trepka, the Vice Chair, called the meeting to order at 10:11 a.m., in the chair's absence.

II. Introductions

Dr. Mary Jo Trepka

Members, guests, and staff introduced themselves.

III. Meeting Housekeeping

Dr. Mary Jo Trepka

Dr. Trepka indicated that a version of the housekeeping presentation was included in the meeting materials for members to reference. As part of housekeeping, Marlen Meizoso will be reviewing the newly revamped website to show the Committee the location of items and new features.

IV. Floor Open to the Public

Dr. Mary Jo Trepka

Dr. Trepka read the following:

Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any items on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.

BSR has a dedicated line for statements to be read into the record. No statements were received. There were no comments, so the floor was closed.

V. Review/Approve Agenda *All*

The Committee reviewed the agenda that was distributed and posted in advance of the meeting. Under Reports, the only report being provided today is from the Part A Recipient.

Motion to accept the agenda, as presented.
Moved: Maria Henriquez Seconded: Dan Wall Motion: Passed

VI. Review/Approve Minutes of December 14, 2023 *All*

The committee reviewed the minutes of December 14, 2023 and approved it as presented.

Motion to accept the minutes from November 8, 2023, as presented.
Moved: Dan Wall Seconded: Maria Henriquez Motion: Passed

VII. Reports

- *Part A* *Dan Wall*

Expenditures to date and clients served were reviewed. The program has served 8, 453 unduplicated clients as of November 2024. The most used service is Medical Case Management. Expenditures are rising and most funds should be expended by the end of the fiscal year.

Sweep #3 letters were sent out last week.

There is one contract pending, which has been in the subrecipient's possession since October and has not been returned.

Food insecurity issues continue, and the Recipient has sent out a letter detailing changes to the Food Bank service category including working with the Miami-Dade County Department of Health in Miami-Dade County (FDOH) to address projected shortfalls. Community resources to local food banks were shared. In addition, locations of EHE providers with food vouchers will be promoted. Cost saving measures for Food Bank include the reduction of FPL for FY 2024, and reinstituting the Letter of Medical Necessity for Food Bank.

The Health Resources and Service Administration will be conducting a site visit January 30-February 2, 2024, and will meet with Recipient and Planning Council staff, Planning Council chairs, members of Executive Committee, representatives of the community, and providers.

- *Vacancies* *Marlen Meizoso*

Marlen Meizoso reviewed the vacancy report as the beginning of January. There are vacancies on all Committees and the Partnership. Currently, there are seven members on Care and Treatment and

nine vacancies. There is one new applicant for membership on the Committee, Louvens Fils-Aime. Mr. Fils-Aime is a Case Manager at SFAN who is currently working with the Jail Linkage program. He introduced himself, expressed his interest in being a member, and the Committee voted to approve him as a member.

Motion to recommend Louvens Fils-Aime as a member of the Care and Treatment Committee.
Moved: Dan Wall Seconded: Dr. Mary Jo Trepka Motion: Passed

VIII. Standing Business

- *Service Standards Approval* *All*

HRSA has requested that the planning council have service standards for all service categories regardless of whether or not the services are funded. While the PCN 16-02 (with local restrictions) was used in the 2022 Needs Assessment, formal approval for FY 2023 was not requested. A draft for FY 2023 and FY 2024 with local restrictions was reviewed, and a motion was made adopting service standards under PCN 16-02 with local restrictions.

Motion to adopt PCN 16-02 service standards retroactively for YR 2023 and for YR 2024 with local restrictions.
Moved: Dan Wall Seconded: Dr. Mary Jo Trepka Motion: Passed

- *Service Categories Development Continued* *All*

The Committee continued its service category development focusing on the emergency financial assistance service category and non-medical case management. Staff distributed a document with HRSA service definitions from PCN 16-02, samples from other Ryan White-funded jurisdictions, other funding data, and requested data on the local Part B program. An inquiry was made regarding the Homeless Trust support for short term stays. The Homeless Trust has contracts with specific locations but does not have a cap; this option is only offered to women with dependent children when shelter space is not available. The Committee had agreed that the Emergency Financial Assistance service should be expanded beyond medications, for electrical utility assistance and rental/emergency housing assistance in response to inclement and extreme weather events. The Committee deliberated on the funding limitations and caps, and opted to mirror the two current caps under Part B. Electric utility assistance would be up to $200 a year per client, and rental/emergency rental assistance would be up to $3,000 a year. Language would need to be added to the service definitions for FY 2025 including a clause indicating funding is limited. Draft language will be provided for review at the next meeting.

The Committee then reviewed the non-medical case management service description. Currently, providers without on-site outpatient/ambulatory health care could not properly provide the service. This service description would allow clients to access agencies who provide services to targeted special populations such as transgender clients, or specific LGBTQ+ groups. The Committee reviewed the development document with the HRSA service definition from PCN 16-02, samples from three other Ryan White-funded jurisdictions, other funding data, and the local Part B program service definition. The Committee discussed the Georgia Case Management definitions for both

medical and non-medical case management, and except for peer encounter being part of medical case management instead of non-medical case management, the tasks listed under non-medical case management seemed appropriate. A statement should be included that non-medical case management may be provided by a person with lived experience. Staff will bring back a similar breakdown for the Committee to review.

At the next meeting, the remaining three services -- housing, psychosocial support, and health education/risk reduction -- will be reviewed.

- *Service Definitions Review: Legal, Food Bank, EFA, Medical Case Management, Medical Transportation* *All*

The Committee reviewed the FY 2024 service definitions for Legal Services, Food Bank, Emergency Financial Assistance, Medical Case Management, and Medical Transportation. These service descriptions have been shared at several prior meetings. The FY 2024 service definitions included updates to priority ranking and dates. Only Food Bank would need additional edits reflecting the cost savings actions, as outlined above. The Committee also reviewed the Food Bank Letter of Medical Necessity which will go into effect next fiscal year. The Committee suggested adding "or licensed nutritionist" as individuals who can complete the form, since some subrecipients employ registered dieticians and others employ nutritionists, but is important that the nutritionist be licenced. The Food Bank Letter of Medical Necessity will be reviewed by the Medical Care Subcommittee and brought back to the Committee.

The Committee motioned to adopt all the other service descriptions as presented with the exception of Food Bank as indicated below.

Motion to accept the draft FY 2024 service definition for Other Professional Services: Legal Services and Permanency Planning, as presented.
Moved: Dan Wall **Seconded: Dr. Daniel Shmuels** **Motion: Passed**

Motion to accept the draft FY 2024 service definition for Emergency Financial Assistance, as presented.
Moved: Dan Wall **Seconded: Dr. Mary Jo Trepka** **Motion: Passed**

Motion to accept the draft FY 2024 service definition for Medical Case Management, Including Treatment Adherence Services, as presented.
Moved: Dan Wall **Seconded: Dr. Daniel Shmuels** **Motion: Passed**

Motion to accept the FY 2024 draft service definition for Medical Transportation, as presented.
Moved: Dan Wall **Seconded: Maria Henriquez** **Motion: Passed**

- *2024 Officer Elections* *All*

The 2024 officer elections memo was reviewed. Today is Dr. Shmuels' last meeting as chair. As indicated at the last meeting, Dr. Mary Jo Trepka is eligible, interested, and accepts the nomination for chair. Unfortunately, there will be a vacancy for a vice-chair since this officer is required to be a Partnership member and not a grantee, and there are no qualified candidates currently on the

Committee.

Motion to accept Dr. Mary Jo Trepka as chair of the Care and Treatment Committee.
Moved: Dan Wall **Seconded: Maria Henriquez** **Motion: Passed**

IX. New Business

- *Passing the Gavel* *All*

Dr. Shmuels thanked the Committee and passed the gavel to the incoming chair, Dr. Trepka, who continued to lead the meeting.

X. Announcements and Open Discussion *All*

Staff announced the 2024 Needs Assessment dates.

Under Open Discussion, members indicated they had no issues to raise.

XI. Next Meeting *Dr. Mary Jo Trepka*

The next meeting was announced but the Committee was asked if they wanted to meet at Behavioral Science Research again instead of the Main Library. Members agreed to stay at BSR and re-evaluate their meeting options next month.

The next meeting is scheduled for Thursday, February 8, 2024, at Behavioral Science Research, 2121 Ponce de Leon Blvd., Ste. 240, Coral Gables, FL 33134, from 10:00 a.m. to 12:00 p.m.

XII. Adjournment *Dr. Mary Jo Trepka*

With business concluded, Dr. Trepka thanked the members for participating in today's meeting, and adjourned the meeting at 11:51 a.m.

Scan to access meeting documents.

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RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **December 2023**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A
Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	6	39	5	18
Health Insurance Premium and Cost Sharing Assistance	0	3,490	0	1,408
Medical Case Management	9,312	88,068	4,569	8,150
Mental Health Services	31	537	21	100
Oral Health Care	742	8,657	555	2,546
Outpatient Ambulatory Health Services	2,361	25,407	1,305	4,277
Substance Abuse Outpatient Care	1	23	1	10
Support Services				
Food Bank/Home Delivered Meals	1,367	20,803	506	1,318
Medical Transportation	484	5,998	176	835
Other Professional Services	26	723	19	79
Outreach Services	38	676	21	196
Substance Abuse Services (residential)	540	4,692	21	69
TOTALS:	14,908	159,113		

Total unduplicated clients (month): 5,364

Total unduplicated clients (YTD): 8,745

See page 4 for Service Unit Definitions

REPORT COMPILED ON: 02/07/2024

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **December 2023**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	6	39	5	18
Health Insurance Premium and Cost Sharing Assistance	0	3,490	0	1,408
Medical Case Management	8,513	78,822	4,214	7,877
Mental Health Services	26	489	17	82
Oral Health Care	742	8,657	555	2,546
Outpatient Ambulatory Health Services	2,223	22,773	1,215	4,090
Substance Abuse Outpatient Care	1	22	1	9
Support Services				
Food Bank/Home Delivered Meals	1,367	20,803	506	1,318
Medical Transportation	484	5,868	176	820
Other Professional Services	26	723	19	79
Outreach Services	34	645	17	167
Substance Abuse Services (residential)	540	4,692	21	69
TOTALS:	13,962	147,023		

Total unduplicated clients (month): 5,056

Total unduplicated clients (YTD): 8,637

REPORT COMPILED ON: 02/07/2024

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **December 2023**

FUNDING SOURCE(S) INCLUDED:

Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
Medical Case Management	799	9,246	448	970
Mental Health Services	5	48	4	18
Outpatient Ambulatory Health Services	138	2,634	102	674
Substance Abuse Outpatient Care	0	1	0	1
Support Services				
Medical Transportation	0	130	0	38
Outreach Services	4	31	4	29
TOTALS:	946	12,090		

Total unduplicated clients (month): 518

Total unduplicated clients (YTD): 1,382

REPORT COMPILED ON: 02/07/2024

Miami-Dade County Ryan White Part A/MAI Program

Service Unit Definitions

Service Categories	Service Unit Definition
Core Medical Services	
AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program; LPAP)	1 filled prescription
Health Insurance Premium & Cost Sharing Assistance	1 health insurance payment (copayment or deductible)
Medical Case Management (MCM; Incl. Treatment Adherence)	1 MCM encounter
Mental Health Services	1 individual or group encounter
Oral Health Care	1 oral health care visit
Outpatient/Ambulatory Health Services	1 medical visit
Substance Abuse Outpatient Care	1 individual or group encounter
Support Services	
Emergency Financial Assistance (limited access)	1 filled prescription
Food Bank	1 bag of groceries
Medical Transportation	1 medical transportation voucher or one-way rideshare trip
Other Professional Services (Legal Assistance & Permanency Planning)	1 hour of legal assistance
Outreach Services	1 individual encounter
Substance Abuse Services-Residential	1 day of residential substance abuse services

NOTE: MAI-funded services are limited to minority clients from priority subpopulations or emerging need subpopulations.

Part A

This report includes YTD paid reimbursements for FY 2023 Part A service months up to December 2023, as of 2/7/2024. This report reflects reimbursement requests that were due by 1/20/2024, and have been paid thus far. Pending Part A reimbursement requests that have been received and are in the review process currently total $5,310,032.61.

RYAN WHITE PART A GRANT AWARD (Grant #: BURW3201)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR33

FORMULA AND SUPPLEMENTAL FUNDING

Per Resolution #s: R-1162-21, R-246-20, R-247-20 & R-817-19

Project #: BURW3302	AWARD AMOUNTS	ACTIVITIES	
Grant Award Amount Formula	16,452,284.00	FORMULA	FY 2023 Award
Grant Award Amount Supplemental	8,484,983.00	SUPPLEMENTAL	$24,937,267
Carryover Award FY'22 Formula	723,098.00	CARRYOVER	
Total Award	**$ 25,660,365.00**		

Note:
The recipient has reached its budgeted direct services Formula minimum expenditures. Until the end of the current period of performace, only budgeted Administrative and Quality Management expenditures and a carryover allowance will be applied to this funding source in order to surpass the 95% minimum expenditure threshold.

CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations
3	AIDS Pharmaceutical Assistance	3,455.00	
8	Health Insurance Services	358,700.00	
2	Medical Case Management	5,979,259.00	
9	Mental Health Therapy/Counseling	61,770.00	
6	Oral Health Care	3,701,975.00	
5	Outpatient/Ambulatory Health Svcs	7,940,909.00	
12	Substance Abuse - Outpatient	6,628.00	
	CORE Services Totals:	18,052,696.00	

Priority Order	Support Services	Allocations	Carryover Allocations	
4	Emergency Financial Assistance	0.00		
7	Food Bank	1,979,244.00	723,098.00	2,702,342
13	Medical Transportation	196,319.00		
15	Other Professional Services	97,449.00		
14	Outreach Services	149,281.00		
10	Substance Abuse - Residential	1,568,552.00		
	SUPPORT Services Totals:	3,990,845.00	723,098.00	
	FY 2023 Award (not including C/O)	22,043,541.00		

DIRECT SERVICES TOTAL:		**$**	**22,766,639.00**
Total Core Allocation	18,052,696.00		
Target at least 80% core service allocation	17,634,832.80		
Current Difference (Short) / Over	**$ 417,863.20**		
Recipient Admin. (GC, GTL, BSR Staff)	**$ 2,293,726.00**		
Quality Management	**$ 600,000.00**		2,893,726.00
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (Formula & Supp)	$ -		
Unobligated Funds (Carry Over)	$ -	$ -	25,660,365.00

Core medical % against Total Direct Service Allocation (Not including C/O):	
Cannot be under 75%	**81.90%** **Within Limit**
Quality Management % of Total Award (Not including C/O):	
Cannot be over 5%	**2.41%** **Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):	
Cannot be over 10%	**9.20%** **Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures
5606970000	AIDS Pharmaceutical Assistance	779.03	
5606920000	Health Insurance Services	211,247.03	
5606870000	Medical Case Management	2,813,747.55	
5606860000	Mental Health Therapy/Counseling	45,045.00	
5606900000	Oral Health Care	2,063,911.00	
5606610000	Outpatient/Ambulatory Health Svcs	5,195,700.59	
5606910000	Substance Abuse - Outpatient	1,380.00	
	CORE Services Totals:	10,331,810.20	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank	1,179,123.80	723,098.00	1,902,221.80
5606460000	Medical Transportation	72,624.57		
5606890000	Other Professional Services	65,025.00		
5606950000	Outreach Services	56,292.09		
5606930000	Substance Abuse - Residential	1,100,250.00		
	SUPPORT Services Totals:	2,473,315.46	723,098.00	
	FY 2023 Award (not including C/O)	12,805,125.66		

TOTAL EXPENDITURES DIRECT SVCS & % :		**$**	**13,528,223.66** **59.42%**
Formula Expenditure %	**82.79%**		
5606710000 **Recipient Administration**	**1,516,514.54**		
5606880000 **Quality Management**	**500,000.00**		2,016,514.54
Grant Unexpended Balance	**FY 2023 Award**	**Carryover**	
	10,115,626.80	-	10,115,626.80
Total Grant Expenditures & %		**$**	**15,544,738.20** **60.58%**

Core medical % against Total Direct Service Expenditures (Not including C/O):	
Cannot be under 75%	**80.68%** **Within Limit**
Quality Management % of Total Award (Not including C/O):	
Cannot be over 5%	**2.01%** **Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):	
Cannot be over 10%	**6.08%** **Within Limit**

MAI

RYAN WHITE PART A GRANT AWARD (Grant#: BURW3201)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR33

MINORITY AIDS INITIATIVE (MAI) FUNDING

Per Resolution #s: R-1162-21, R-246-20, R-247-20 & R-817-19

This report includes YTD paid reimbursements for FY 2023 MAI service months up to December 2023, as of 2/7/2024. This report reflects reimbursement requests that were due by 1/20/2024, and have been paid thus far. Pending MAI reimbursement requests that have been received and are in the review process currently total $190,048.56.

PROJECT #: BURW3302	AWARD AMOUNTS	ACTIVITIES
Grant Award Amount MAI	2,621,581.00	MAI
Carryover Award FY'22 MAI	980,218.00	MAI_CARRYOVER
Total Award	**$ 3,601,799.00**	

CONTRACT ALLOCATIONS

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations		
	AIDS Pharmaceutical Assistance				
	Health Insurance Services				
1	Medical Case Management	578,218.00	490,109.00	1,068,327.00	
4	Mental Health Therapy/Counseling	18,960.00			
	Oral Health Care				
5	Outpatient/Ambulatory Health Svcs	1,031,538.00	490,109.00	1,521,647.00	
8	Substance Abuse - Outpatient	8,058.00			
	CORE Services Totals:	1,636,774.00	980,218.00		

Priority Order	Support Services	Allocations	Carryover Allocations		
6	Emergency Financial Assistance	0.00			
	Food Bank				
9	Medical Transportation	7,628.00			
	Other Professional Services				
10	Outreach Services	39,816.00			
	Substance Abuse - Residential				
	SUPPORT Services Totals:	47,444.00			
	FY 2023 Award (not inlcuding C/O)	1,684,218.00			

DIRECT SERVICES TOTAL:		**$ 2,664,436.00**	
Total Core Allocation	1,636,774.00		
Target at least 80% core service allocation	1,347,374.40		
Current Difference (Short) / Over	**$ 289,399.60**		
Recipient Admin. (OMB-GC)	**$ 262,158.00**		
Quality Management	**$ 100,000.00**	362,158.00	$ 3,026,594.00
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (MAI)	**$ 575,205.00**		
Unobligated Funds (Carry Over)	$ -	575,205.00	3,601,799.00

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures	
5606970000	AIDS Pharmaceutical Assistance			
5606920000	Health Insurance Services			
5606870000	Medical Case Management	271,004.75	215,884.65	486,889.40
5606860000	Mental Health Therapy/Counseling	2,470.00		
5606900000	Oral Health Care			
5606610000	Outpatient/Ambulatory Health Svcs	501,602.91	155,095.36	656,698.27
5606910000	Substance Abuse - Outpatient	30.00		
	CORE Services Totals:	775,107.66	370,980.01	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank			
5606460000	Medical Transportation	7,616.40		
5606890000	Other Professional Services			
5606950000	Outreach Services	19,908.00		
5606930000	Substance Abuse - Residential			
	SUPPORT Services Totals:	27,524.40		
	FY 2023 Award (not inlcuding C/O)	802,632.06		

TOTAL EXPENDITURES DIRECT SVCS & %:		**$ 1,173,612.07**	**44.05%**
5606710000	**Recipient Administration**	**113,939.47**	
5606880000	**Quality Management**	**83,333.30**	197,272.77

	FY 2023 Award	Carryover	
Grant Unexpended Balance	**1,621,676.17**	**609,237.99**	2,230,914.16
Total Grant Expenditures & % (Including C/O):		**$ 1,370,884.84**	**38.06%**

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**97.18%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.81%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**10.00%**	**Within Limit**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**96.57%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.18%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**4.35%**	**Within Limit**

Printed on: 2/7/2024

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

AGENDA

I.	Call to Order	Dr. Mary Jo Trepka
II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 11, 2024	All
VII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Medical Care Subcommittee Items	Dr. Mary Jo Trepka
	• Vacancies	Marlen Meizoso
VIII.	Standing Business	
	• Service Standards	All
	• Service Categories Development Continued	All
	• Service Definitions Review: Food Bank	All
	• Vice Chair Position	All
IX.	New Business	
	• Clarification of Prior Motion: Date	All
	• Service Definition Review: Outreach and Health Insurance	All
	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Mary Jo Trepka

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Provider Agency Name & Address
FDOH in Miami-Dade County
1350 N.W. 14th St.,
Miami, 33125

Florida Department of Health

Expenditure/Invoice Report

Program Name: Patient Care-Consortia

Area Name:AREA 11A

Month: November

Year: 2023-2024

Report generated on: 02/07/2024

Contract Name: 2023-2024 Miami Dade CHD RW Consortia

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
Administrative Services	November	0	0	$125,915.00	$9,316.99	$61,289.07	49%
Medical Case Management (including treatment adherence)	November	53	8,610	$120,000.00	$9,901.50	$71,121.75	59%
Mental Health Services - Outpatient	November	20	70	$30,000.00	$2,275.00	$15,925.00	53%
Emergency Financial Assistance	November	43	63	$845,780.00	$49,159.16	$308,712.98	37%
Non-Medical Case Management Services	November	13	13	$273,970.00	$10,581.05	$147,567.51	54%
Referral for Health Care/Supportive Services	November	771	771	$181,451.60	$10,664.33	$104,217.41	57%
Clinical Quality Management	November	0	0	$68,508.03	$1,655.16	$24,141.02	35%
Planning and Evaluation	November	0	0	$34,224.37	$2,935.17	$24,846.99	73%
Totals		**900**	**9527**	**$1,679,849.00**	**$96,488.36**	**$757,821.73**	

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend

ADVANCE(S) INFORMATION:

Total Advances	$0.00
Previous Reductions	$0.00
Current Reductions	$0.00
Remaining Advances	$0.00

Total Contract Amount	$1,679,849.00
Minus Expended Y-T-D	$757,821.73
Minus UNPAID Advances	$0.00
Balance To Draw	$922,027.27

Total Expenditures this period:	$96,488.36
Less Advance Payback this period:	$0.00
AMOUNT OF FUNDS REQUESTED THIS REPORT:	**$96,488.36**

I certify that the above report is a true, accurate and correct reflection of the activities this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature & Title of Provider Agency Official | **Date** | **Contract Manager Signature** | **Date**

Contract Manager's Supervisor Signature | **Date**

Provider Agency Name & Address
FDOH in Miami-Dade County
1350 N.W. 14th St.,
Miami, 33125

Contract Name: 2023-2024 Miami Dade CHD RW Consortia

Florida Department of Health

Expenditure/Invoice Report

Program Name: Patient Care-Consortia

Area Name:AREA 11A

Month: December

Year: 2023-2024

Report generated on: 02/07/2024

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend
Administrative Services	December	0	0	$125,915.00	$7,402.41	$68,691.48	55%
Medical Case Management (including treatment adherence)	December	10,890	69	$120,000.00	$12,523.50	$83,645.25	70%
Mental Health Services - Outpatient	December	29	11	$30,000.00	$942.50	$16,867.50	56%
Emergency Financial Assistance	December	85	108	$845,780.00	$50,934.67	$359,647.65	43%
Non-Medical Case Management Services	December	21	21	$273,970.00	$10,140.35	$157,707.86	58%
Referral for Health Care/Supportive Services	December	789	789	$181,451.60	$12,626.26	$116,843.67	64%
Clinical Quality Management	December	0	0	$68,508.03	$1,537.09	$25,678.11	37%
Planning and Evaluation	December	0	0	$34,224.37	$2,651.63	$27,498.62	80%
Totals		**11814**	**998**	**$1,679,849.00**	**$98,758.41**	**$856,580.14**	

Contract Services	Expended Month	# of Clients	# of Service Units	Approved Budget	Expended Budget	Expended Y-T-D	Rate of Expend

ADVANCE(S) INFORMATION:

Total Advances	$0.00
Previous Reductions	$0.00
Current Reductions	$0.00
Remaining Advances	$0.00

Total Contract Amount	$1,679,849.00
Minus Expended Y-T-D	$856,580.14
Minus UNPAID Advances	$0.00
Balance To Draw	$823,268.86

Total Expenditures this period:	$98,758.41
Less Advance Payback this period:	$0.00
AMOUNT OF FUNDS REQUESTED THIS REPORT:	**$98,758.41**

I certify that the above report is a true, accurate and correct reflection of the activities this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature & Title of Provider Agency Official | **Date** | **Contract Manager Signature** | **Date**

Contract Manager's Supervisor Signature | **Date**

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

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IX.	New Business	
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	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
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During the month of December a total of 564 clients received services, 200 received medical case management and 87 received Outpatient services. Our Salvation Army beds are full and have continue, curretnly we have a waiting list.

General Revenue July 2023 - June 2024

HIV/AIDS Demographic Data for PHT/SFAN

	December 23			Year To Date Data		
	Unduplicated Client Count	Units	Dollar Amt.	Total Dollar Amt.	Annual Budget	YTD Units
Ambulatory - Outpatient Care	87	109	53,585.34	592,913.09	1,792,649.00	2,908
Drug Pharmaceuticals	17	25	21,065.41	91,425.74	677,778.00	242
Oral Health			-	-	50,000.00	-
Home & Community Base Services				-	2,000.00	
Home Health Care				-	30,000.00	47
Mental Health Services	35	56	7,008.66	43,497.06	115,854.00	228
Nutrition Counseling				2,856.40	20,000.00	20
Medical Case Management	200	200	34,235.27	785,783.20	1,309,687.00	10,089
Sustance Abuse Services					93,000.00	
Non-Medical Case Management			50,403.81	252,911.75	630,735.00	457
Other Support Services / Emergency Fin. Assistance	5	5	12,300.75	108,535.95	170,000.00	41
Psychosocial Support Services					55,000.00	
Transportation	154	308	4,496.80	38,215.39	77,250.00	954
Referral for Health Care / Supportive Services	61	171	54,676.03	161,968.26	420,820.00	705
Substance Abuse Residential				64,518.51	281,955.00	237
Residential Care - Adult	- 5	155		51,428.00	204,035.00	1,754
Nursing Home Care			41,815.59	280,475.57	470,000.00	900
Hospital Services						
	564	1,029	279,587.66	2,474,528.92	6,400,763.00	18,582

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
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XII.	Adjournment	Dr. Mary Jo Trepka

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
January 26, 2024 Meeting Report
to the Care and Treatment Committee
Presented February 8, 2024

The Medical Care Subcommittee (MCSC):

- Heard updates from the Ryan White Program and AIDS Drug Assistance Program (ADAP).

- Elect James Dougherty, Chair and Cristhian Ysea, Vice Chair.

- Reviewed and finalized edits to the Ryan White Primary Medical Care Standards. A request was made to add associate to physician assistance since the term has been updated. The revised draft is attached.

    1. **Motion to accept the Miami-Dade County Ryan White Program Minimum Primary Medical Care Standards with the addition of associate to physician assistant.**

- Reviewed and made several edits to the AIDS Pharmaceutical, Mental Health, and Outpatient Ambulatory Health Service descriptions including necessary updates to priorities, dates, and language. Revised drafts are attached. Items in highlight will be updated once sources are available.

    2. **Motion to accept the changes to the AIDS Pharmaceutical Service Description as discussed.**
    3. **Motion to accept the changes to the Mental Health Service Description as discussed.**
    4. **Motion to accept the changes to the Outpatient Ambulatory Health Services description as discussed.**

- The Care and Treatment Committee made some suggested changes to the Nutritional Assessment Letter for Extension of Occurrences of Food Bank Services and the Medical Care Subcommittee reviewed some additional changes to content and formatting. The revised draft is attached.

    5. **Motion to accept the changes to the Nutritional Assessment Letter for Extension of Occurrences of Food Bank Services as discussed.**

The next MCSC meeting is scheduled for February 23, 2024, at Behavioral Science Research Corp.

All motions are subject to Partnership approval.

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.

RYAN WHITE PROGRAM
Nutritional Assessment Letter for Extension of Occurrences of Food Bank Services

This letter is required for additional Food Bank occurrences beyond the annual twenty (20) occurrences (visits)
To be completed by licensed medical prescriber or registered dietitian* or licensed nutritionist* (*not associated with Part A food bank provider)

Client's Full Name:_____

Licensed Medical Prescriber attestation:
As prescriber for this client, it is my professional opinion that they require an extension of food bank services.

_____
Licensed Medical Prescriber Signature and Date

_____ _____
Printed Name of Licensed Medical Prescriber **License # (MD, DO, PAs, APRN)**

OR

Registered dietitian or licensed nutritionist attestation:
As the nutritional professional who has completed an assessment for this client, it is my professional opinion that they require an extension of food bank services.

_____
Registered Dietitian or Licensed Nutritionist Signature and Date

_____ _____
Printed Name of Registered Dietician or Licensed Nutritionist **Registered Dietitian or Licensed Nutritionist License #**

Number of Additional Occurrences Requested (**maximum sixteen (16)** additional occurrences within the current Ryan White Part A fiscal year): ☐ which will assistance with maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving

The client has the following **severe** change of status (check all that apply):

☐ New HIV-related diagnosis/symptom (please describe) e.g., OI, AIDs diagnosis, etc._____

☐ Wasting Syndrome

☐ Protein imbalance

☐ Recent chemotherapy

☐ Recent hospitalization

☐ Other medical reasons:
_____

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Services Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

REVISED: TBA

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

AGENDA

I.	Call to Order	Dr. Mary Jo Trepka
II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 11, 2024	All
VII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Medical Care Subcommittee Items	Dr. Mary Jo Trepka
	• Vacancies	Marlen Meizoso
VIII.	Standing Business	
	• Service Standards	All
	• Service Categories Development Continued	All
	• Service Definitions Review: Food Bank	All
	• Vice Chair Position	All
IX.	New Business	
	• Clarification of Prior Motion: Date	All
	• Service Definition Review: Outreach and Health Insurance	All
	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Mary Jo Trepka

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership/

MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

February 2, 2024

The Miami-Dade HIV/AIDS Partnership

The official Ryan White Program Planning Council in Miami-Dade County and the Advisory Board for HIV/AIDS to the Miami-Dade County Mayor and Board of County Commissioners. Complete a brief New Member Interest Form to find out more: www.surveymonkey.com/r/DRJP5N5 or scan the QR code.

Opportunities for Ryan White Program Clients

12 *seats are available to Ryan White Program Clients who are not affiliated or employed by a Ryan White Program Part A funded service provider.*

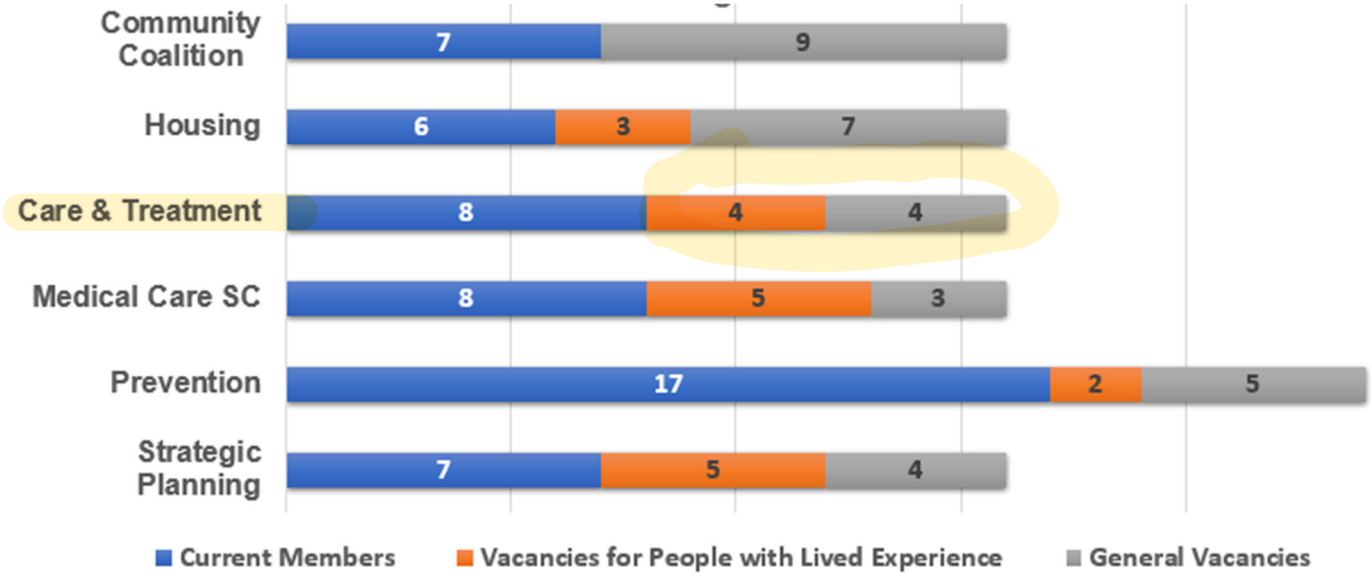
Opportunities for General Membership

6 *seats are open to people with HIV, service providers, and community stakeholders who have reputations of integrity and community service, and possess the relevant knowledge, skills and expertise in these membership categories:*

Representative with HIV and Hepatitis B or C
Other Federal HIV Program Grantee Representative (SAMHSA)
Federally Recognized Indian Tribe Representative
Hospital or Healthcare Planning Repreasentative
Mental Health Provider Representative
Miami-Dade County Public Schools Representative

Partnership Committees

Committees are now accepting applications for new members.



People with HIV are encouraged to apply.

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
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10:00 a.m. – 12:00 p.m.

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Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership/

Note: items in red show local restrictions

Miami-Dade Ryan White Program Service Standard Excerpts for FY 2023 and FY 2024

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

RWHAP Core Medical Services (*funded in Miami-Dade)

AIDS Drug Assistance Program Treatments

AIDS Pharmaceutical Assistance*

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals*

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services*

Medical Nutrition Therapy

Mental Health Services*

Oral Health Care*

Outpatient/Ambulatory Health Services*

Substance Abuse Outpatient Care*

RWHAP Support Services

Child Care Services

Emergency Financial Assistance*

Food Bank*/Home Delivered Meals

Health Education/Risk Reduction

Housing

Linguistic Services

Medical Transportation*

Non-Medical Case Management Services

Other Professional Services*(Legal Services and Permanency Planning)

Outreach Services*

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)*

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

[5] https://aidsinfo.nih.gov/guidelines

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

   HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:
   - Uniform benefits for all enrolled clients throughout the service area
   - A recordkeeping system for distributed medications
   - An LPAP advisory board
   - A drug formulary that is
     - Approved by the local advisory committee/board, and
     - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
   - A drug distribution system
   - A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
   - Coordination with the state's HRSA RWHAP Part B ADAP
     - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
   - Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)
2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:
Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. LOCAL RESTRICTION ON HEALTH INSURANCE: Standalone dental insurance is not included. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral

health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care 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' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services

- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services

Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:

Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

Mental Health Services
Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category. LOCAL RESTRICTION ON URGENT CARE: Per decisions made by the local planning council, the Ryan White Program in Miami-Dade does not include Urgent Care services at all under Outpatient/Ambulatory Health Services.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

RWHAP Legislation: Support Services

Child Care Services
Description:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. LOCAL RESTRICTION ON EMERGENCY FINANCIAL ASSISTANCE: This service is restricted to prescription drugs.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals

Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:

Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction

Description:

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:

Health Education/Risk Reduction services cannot be delivered anonymously.

Housing

Description:

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

- Contracts with providers of transportation services

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and

personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Professional Services
Description:
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. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - 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 HRSA RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills
- Permanency planning to help 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:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits. LOCAL RESTRICTION ON INCOME TAX PREPARATION: The Miami-Dade Ryan White Program should not include income tax preparation as a component because there are other local sources for this service, e.g. the United Way Center for Financial Stability's Volunteer Income Tax Assistance program.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Permanency Planning

See Other Professional Services

Psychosocial Support Services

Description:

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:

Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

Rehabilitation Services

Description:

Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services

Description:

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Respite Care
Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:

Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

AGENDA

I.	Call to Order	Dr. Mary Jo Trepka
II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 11, 2024	All
VII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Medical Care Subcommittee Items	Dr. Mary Jo Trepka
	• Vacancies	Marlen Meizoso
VIII.	Standing Business	
	• Service Standards	All
	• Service Categories Development Continued	All
	• Service Definitions Review: Food Bank	All
	• Vice Chair Position	All
IX.	New Business	
	• Clarification of Prior Motion: Date	All
	• Service Definition Review: Outreach and Health Insurance	All
	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Mary Jo Trepka

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment Committee Service Definitions Development
February 8, 2024

Purpose

At the September, 2023 meeting, the Care and Treatment Committee (Committee) approved five new support service categories for consideration for the next Ryan White Program Part A/MAI Request for Proposals cycle. This document is intended to assist the Committee in the development of service descriptions for the new service categories.

The Health Resources and Services Administration (HRSA) service definitions from Policy Clarification Notice #16-02 and samples from other Ryan White-funded jurisdictions are included in this document.

Services, Notes, and Task Status

Services	Notes	Status
Emergency Financial Assistance (EFA)	Recommended language has been added to the draft mirroring current Part B guidance. Should eligibility for this service be set at 400% federal poverty level or lower?	**In Process**
Non-Medical Case Management (non-MCM)	Draft materials should be available for the March meeting	**In Process**
Psychosocial Support Services	Funded under Part D.	Not started
Health Education/Risk Reduction	Funded under some Part Cs and Part D.	Not started
Housing	Some funding under HOPWA and EHE.	Not started

Emergency Financial Assistance **Status:** Currently funded support service

Other Funders (based on 2023 Needs Assessment):
General Revenue $147,358; Part B $520,191

HRSA PCN# 16-02 Definition (pg. 17)

Description:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program (ADAP) or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. EFA must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

EFA funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the EFA category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Other Sample Services:

- Washington, DC EMA
- Los Angeles County, CA EMA
- Texas, Part B

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 within one of these components required to improve health outcomes that are associated with other approved service categories. 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. 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.

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.

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). Services restricted to usage only during weather related emergencies.

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). Services are restricted to usage only during weather related emergencies.

Non-Medical Case Management Services **Status:** Currently unfunded support service

Other Funders (based on 2023 Needs Assessment): General Revenue $547,953; Part B $147,961; Part C $120,593; Part D $71,955

HRSA PCN#16-02 Definition (pg. 20-21)

Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs.
- Development of a comprehensive, individualized care plan.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Client-specific advocacy and/or review of utilization of services.
- Continuous client monitoring to assess the efficacy of the care plan.
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary.
- Ongoing assessment of the client's and other key family members' needs and personal support systems.

Program Guidance:

NMCM services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Sample Services:

- Washington, DC EMA
- Texas, Part B
- Georgia, Part B

Psychosocial Support Services **Status:** Currently unfunded support service

Other Funders (based on 2023 Needs Assessment): Part D $53,204

HRSA PCN#16-02 Definition (pg. 23)

Description:

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services

***Program Guidance*:**

Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

Other Sample Services:

- Washington, DC EMA
- Cleveland, OH TGA
- Miami-Dade, FL EMA (former definition to be found)

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Psychosocial Support Services

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Psychosocial Support Services provides individual and/or group support and counseling services to address customers' continuing behavioral and physical health concerns. Psychosocial support should be delivered by staff, volunteers, and/or peers to help clients access health and benefits information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, helping improve quality of life for participants. Key activities include:

- Support and counseling activities
- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services
- Caregiver support

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

- Current lease or mortgage statement
- Deed settlement agreement
- Current driver's license
- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
   - Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data

13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES	
Standard	**Measure**
Prior to the initiation of the psychosocial support service plan, customers are assessed for: ● support system and psychosocial support needs ● history of accessing primary care and other services and barriers to access— noting psychosocial support barriers in particular	Documentation of intake and assessment in customer's record signed and dated by psychosocial support staff
The type and level of psychosocial support services to be delivered must be documented in an existing Ryan White service plan or outlined in a new support plan. The plan for psychosocial support services must include identified problem(s), goal(s) to address problem, and target date for completion.	Psychosocial support service plan, documented in customer record, signed, and dated by the customer and psychosocial support staff
Psychosocial support service plan is reassessed every 90 days to review customer's treatment adherence as well as engagement and retention in in primary care and medical case management **Exclusions** Funds under this service category may not be used for social/recreational activities or to pay for a customer's gym membership.	Documentation of reviewed and updated of psychosocial support service plan as appropriate signed and dated by customer and psychosocial support staff. Documentation should indicate topics covered, activities conducted, and goals achieved. Additional activities in the client record, if applicable, must include: ● Progress notes for each contact with client by phone or at face-to-face meetings ● Progress notes recording activities on behalf of the client to implement the Support Plan ● Progress toward goals ● Communications with referring agency (e.g., missed/kept appointments, etc.) ● Contacts with client (by phone or face-to-face), depending on client need ● Documentation of follow-up for referred services ● Documentation of follow-up to missed appointments ● Management of emergency situations as they arise ● Adjustment to support plan, if necessary ● Case conferencing when necessary ● Crisis intervention when necessary
Customers may receive support counseling in either an individual or group format. Counseling must be	Documentation of counseling services provided in customer record, indicating:

conducted by a qualified individual (professional or peer) and should be structured, with a treatment plan or curriculum, to move clients towards attainable goals. Pastoral care/counseling must be available to all eligible customers regardless of religious denominational affiliation and must be provided by: ● An institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider ● A licensed or accredited provider, wherever such licensure or accreditation is either required or available	● Date of session ● Duration of session ● Name and title of the group, if applicable ● General topics discussed ● Summary of activities conducted ● Goals and objectives selected and achieved during the session(s)
Customers may receive nutritional counseling services (e.g., nutrition education, assessment, and counseling) by a non-registered dietitian to assist them in: ● Maintaining treatment regimens ● Remaining in primary medical care ● Using food products in the best way possible to maintain or improve health and maximize health benefits *Note: A nutritional plan cannot be developed by a registered dietitian under this service category.* **Exclusions** ● Funds under this service category may not be used to provide nutritional supplements (*See Food Bank/Home-Delivered Meals).*	Documentation of nutritional service(s) provided in customer record
Customers may receive bereavement counseling	Documentation of bereavement counseling provided in customer record
The provider must ensure that referrals and linkages to other services, such as mental health and substance abuse treatment, are made as appropriate and documented with the status of outcomes	Documentation of referral(s) in customer's record
TRANSITION & DISCHARGE	
Standard	**Measure**
Customer discharged when psychosocial support services are no longer needed, goals have been met, upon death or due to safety issues. <u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. <u>Documentation</u>: Customer's record must include: ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge ● Reason(s) for discharge

present to sign for the letter, it must be returned to the provider. Transfer: If customer transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.	● Referrals made at time of discharge, if applicable
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals	Documentation of case closure in customer's record with clear rationale for closure

● Decides to transfer to another agency ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan ● Exhibits pattern of abuse as defined by agency's policy ● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison, or inpatient program ● Is deceased	

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

At minimum, all psychosocial support service staff and volunteers must have a high school diploma or GED plus one year of social service experience. Qualifying life experience may substitute educational and professional requirements. They must be able to provide linguistically and culturally appropriate services for people living with HIV, and complete documentation as required by their positions. Staff will be sensitive to the needs of persons of diverse life experiences, including customers with substance use disorder, mental illness, with co-occurring disorders and, ideally, will have prior experience working with the target population. Staff and volunteers will also be trained in or have relevant experience in core competencies:

- Active listening and other one-on-one support skills
- Group facilitation, if applicable
- Conflict de-escalation/resolution
- Roles and responsibilities of peer emotional support
- Client assessment skills, including:
    - Conducting an initial needs assessment (as appropriate to job function)
    - Identifying an individual at imminent risk who is in need of a higher level of support
- Awareness of resources for appropriate referral

All newly hired psychosocial support services staff and volunteers must complete the following trainings:

a. HIV 101, including impacted communities, disease process, co-morbidities, and psychosocial effects of the virus
b. HIV counseling and testing
c. HIV care system, resources, and access
d. Motivational interviewing
e. Information and techniques for working with substance use disorder
f. Sexual health and risk

g. Gender competency
h. Names reporting
i. Cultural Awareness, sensitivity, and competency
j. Consent laws, client confidentiality, Health Insurance Portability and Accountability Act (HIPAA), client rights, and agency grievance procedures
k. Entitlement programs, benefits to clients, and community resources/support services

In addition to attending the above, all psychosocial support services staff and volunteers are required to attend ongoing annual training on topics related to their position, including, but not limited to:

a. Sexual health
b. Substance use disorder, sensitivity and cultural approaches and related issues
c. Mental health
d. Domestic violence
e. Sexually transmitted infections (STIs)
f. Partner notification
g. Bereavement
h. Cultural and linguistic competence
i. Nutrition

Pastoral Care Counselor

- All pastoral care counselors must have appropriate and valid licensure as required by their jurisdiction.

Psychosocial Support Services Supervisor

- All non-professional staff delivering psychosocial support services must be supervised by a licensed professional.
- The supervisor of psychosocial support staff must be appropriately trained, knowledgeable and highly competent in the areas of HIV/AIDS, substance use disorder, community referrals, educational services, general computer skills, and the areas of competence and training expected of psychosocial support staff.
- Supervisors will have at least two years of work experience with related populations or issues.
- Supervisors will also complete the trainings required of new psychosocial support service staff, as noted in this section.

V CLINICAL QUALITY MANAGEMENT

A continuous Clinical Quality Management Program for HIV patient care. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

Every agency that provides Ryan White supported Substance Abuse services must develop and implement a Quality Management (QM) Plan. The QM Plan should be actively supported and guided by the formal agency leadership and senior administration, and appropriate resources should be committed to support continuous quality improvement activities. Agencies with multiple funded service categories must integrate the Substance Abuse QM Plan into their broader QM Plan and specifically address HIV-related services. The QM Plan must be in writing. At least once a year, the QM Plan must be reviewed and updated routinely by the QM committee. Staff from all levels of the agency, as well as patients should serve on the QM committee. Each member of the committee should be aware of the QM infrastructure. However, all agency staff regardless of their participation on the committee must understand their role in the agency's/program's quality improvement activities.

Psychosocial Support Services

SERVICE CATEGORY DEFINITION

Psychosocial Support Services:

Psychosocial Support Services provide group or individual support and counseling services to include HIV support groups to assist eligible people living with HIV to address behavioral and physical health concerns.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- ◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- ◊ Have an HIV/AIDS diagnosis
- ◊ Have a household income that is at or below 500% of the federal poverty level
- ◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Psychosocial Support Services

PERSONNEL QUALIFICATIONS

An individual providing psychosocial support services must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of psychosocial support services is to provide group support and therapy for people living with HIV/AIDS that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for psychosocial support services are:

- 80% of psychosocial support clients have received education specifically geared towards the importance of medical adherence.
- 80% of psychosocial support clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Psychosocial Support Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	* Psychosocial Support services are provided by qualified professionals	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	100%
2	* Documentation is maintained of all topics discussed through support group with correlating sign-in sheets.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
3	* Access and engagement in primary care topics were discussed with the client at least once in a 3 month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
4	* Access and engagement in medical case management was discussed with the client at least once in a six month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
5	Psychosocial client is linked to medical care.	Documentation that client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report).	80%
6	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Psychosocial Support Services

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

PSYCHOSOCIAL SUPPORT SERVICES
(Year 22 Service Priority #14)

This service offers non-judgmental psychosocial support/pastoral care treatment and counseling services including individual, group, and crisis intervention counseling provided by non-licensed psychosocial support counseling providers, peers, and pastoral care counselors. **Psychosocial Support Services** may be delivered in individual or group settings. **Please note that Ryan White Part A Programs funds for this service may not be used for bereavement support for uninfected family members or friends.**

Psychosocial support services reimbursed under the Ryan White Part A Program are limited to conditions stemming from and treated within the context of the client's HIV/AIDS diagnosis. This service is not intended to be general psychosocial practice, but is intended to address HIV-related issues and strengthen coping skills to increase adherence and access to on-going medical care and treatment.

PLEASE NOTE: All initial assessments and subsequent assignments to Level III and Level IV psychosocial support services will be done by a licensed Level I or Level II mental health professional. If counseling is provided by a non-licensed professional and/or peer counselor, oversight and supervision must be conducted by a licensed professional or a professional exempt from licensing under F.S. 491.014. The supervisor will approve and sign progress notes, mini-evaluations, and referrals. It is important for the Level I or Level II mental health professional to regularly gauge the client's progress, and determine if the client is still in need of the service. There should be clear documentation that on-going Level III or Level IV counseling is being reviewed and supervised by a licensed professional, and that the on-going counseling remains appropriate. This documentation can be achieved through updated referrals by a Level I or Level II mental health professional every 6 months, to accompany a Ryan White Program Certified Referral to a Level III or Level IV psychosocial support service provider.

Reimbursement will be differentiated according to the level of intensity of the service and the training of the direct service practitioner, as follows:

- **Psychosocial Support Services/Counseling (Level III)** - This service includes *general* psychosocial support counseling (individual, family, and group) provided by a *Bachelor's degree* level or *unlicensed Master's degree level provider* (MSW or MS only) provider in the appropriate counseling-related field.

- **Pastoral Care and Support Services** – Pastoral Care and Support Services is equivalent to Level III psychosocial support counseling with respect to the qualifications of counseling staff. Pastoral care counselors must: (1) hold a Master's degree in theology, philosophy,

social work, or psychology from an accredited institution; and (2) have completed at least four units (1,600 hours or one full year) in clinical pastoral education (CPE) in an institution accredited by one of the following professional associations: the Association of Clinical Pastoral Education, National Association of Catholic Chaplains, National Association of Jewish Chaplains, American Institute of Islamic Studies, or Canadian Association of Pastoral Education.

- **Psychosocial Support Services/Counseling (Level IV)** – This service includes supportive counseling by trained and supervised HIV-infected or affected peers. Activities include forming or strengthening support groups and other areas appropriate for individual and group socio-emotional support related to conditions and situations stemming from a client's HIV status.

Psychosocial Support Services/Counseling Components:

Level III – Provides supervised psychosocial support/counseling designed to improve the client's psychosocial health and promote feelings of well-being. Services will include crisis counseling, periodic re-assessments, and re-evaluations of plans and goals documenting progress. Goals should be measurable and include a timeline for completion. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to mental health and medical treatments, depression, and safer sex will be addressed. Psychosocial support counselors are encouraged to practice and introduce motivational interviewing and harm reduction strategies with their clients, if deemed clinically appropriate. Counseling at this level may include relationship difficulties, client-centered advocacy, stress management and coping skills, personal and social adjustments as they relate to HIV/AIDS, and the provision of needed information and education to clients to enhance their quality of life. Services at this level are provided for clients experiencing mild to moderate mental or emotional 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].

Pastoral Care and Support Services – This service assists HIV+ persons, members of their immediate family and of their household, in the clarification/identification of their own resources/tasks/priorities and in the development and/or enhancement of their resources through individual or family/household pastoral care sessions. Pastoral Care Counselors will work with clients to clarify the spiritual and pragmatic options that order and validate the client's individual life experiences, strengthen their belief systems, purpose, and values as related to their HIV status. Pastoral care counseling is an intervention at a point of need in a client's life that strives to progressively move the client along a continuum of self-acceptance and responsibility. Pastoral care counseling must be available to all individuals eligible to receive Ryan White Program services, regardless of the client's religious or denominational affiliation.

Level IV – This service provides supervised peer support and advice through coaching, information sharing, listening, and role modeling in groups and limited individual settings. Its primary goal is the promotion of an independent living philosophy wherein the client becomes his or her own self-advocate. Individual support counseling will be provided only within the guidelines and goals of a treatment plan developed by a professional mental health counselor with assistance and consultation with the peer support worker. The peer support counselor will provide timely feedback and information to the professional mental health counselor in order to monitor client progress. Support counseling will address adherence to mental health and medical treatments. Support counselors will not make referrals themselves, but will consult and make known to his or her supervisor information/changes in the client's condition that may require a referral. Appropriate referrals will then be made by the supervisor.

Group Counseling (Levels III and Pastoral Care) - a group of individuals (minimum of three (3) Ryan White clients, maximum of fifteen (15) total clients) with similar problems meeting under the expert guidance of a trained psychosocial support or pastoral support professional. Members of the group will be selected by the psychosocial support or pastoral support 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 counselor an opportunity to observe how an individual interacts with others.

Support (Group) Counseling (Level IV) – a group of individuals [minimum of three (3) Ryan White clients, maximum of fifteen (15) total clients] with similar problems meeting with a supervised peer. These groups provide emotional support and validation through discussion of shared problems and feelings. Such support may take the form of ego-empowerment, encouragement, positive affirmation or more objective methods, as in helping to plan specific courses of action, giving advice on how to solve an immediate problem, etc. Services at this level are provided for clients experiencing mild functional or emotional problems and are generally not provided on a long term basis.

A. **Program Operation Requirements:** Staff must demonstrate knowledge of HIV disease, its psychosocial dynamics and implications, including cognitive impairment, and generally accepted treatment modalities and practices. Services may be delivered to non-HIV family members (as defined by the client) only if the HIV+ client is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of support group participants to counselors should be no lower than 3:1 and no higher than 15:1. One visit is equal to one half-hour counseling session.

B. **Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half hour counseling session not to exceed $25.00 per unit for Level III and Pastoral Care individual counseling; $27.00 per unit for Level III

and Pastoral Care group counseling; $15.00 per unit for Level IV individual counseling; and $20.00 per unit for Level IV group support counseling. Reimbursement for individual counseling units are calculated for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are calculated for the counselor that provided the group therapy (i.e., number of group counseling units per counselor).

C. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a one-half-hour counseling session and the unduplicated number of clients served. Providers will report individual and group activity separately for Level III, Level IV, and pastoral care counseling services.

D. **Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for a client to receive a Level III, Level IV, or pastoral care psychosocial support service and must be updated every six (6) months. Additionally, a medical referral from a licensed Level I or Level II mental health professional (indicating that the client is suitable for Level III or Level IV psychosocial support counseling) is also required. Documentation of the medical referral must be indicated in the Ryan White Program Certified Referral, or must accompany the OON Referral. Clients receiving Ryan White Program Part A-funded psychosocial support services must be documented as having a gross household income below 300% of the 2012 Federal Poverty Level (FPL).

E. **Additional Rules for Documentation:** Providers of psychosocial support services must maintain documentation demonstrating that funds are used only for allowable services. Providers must also maintain client charts that include treatment plans with all required elements, including but not limited to measurable goals and timelines for completion. Documentation in the client chart must also clearly indicate that services were provided as allowable under the Ryan White Program service definition, and include the quantity, frequency and modality of treatment services, the date treatment begins and ends, regular monitoring and assessment of client progress, and a signature of the individual providing the service or the supervisor as applicable. Providers must also maintain, and submit to OMB-GC upon request, proof that psychosocial support service staff meets all applicable federal, state, or local requirements.

Health Education/Risk Reduction **Status:** Currently unfunded support service

Other Funders (based on 2023 Needs Assessment): Health Education-Part C $357,706; Part D $23,982; Risk Reduction-Part D $48,001

HRSA PCN# 16-02 Definition (pg. 18)

Description:

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre- exposure prophylaxis (PrEP) for clients' partners and treatment as prevention.
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage).
- Health literacy.
- Treatment adherence education.

Program Guidance:

Health Education/Risk Reduction services cannot be delivered anonymously.

Other Sample Services:

- Santa Clara, CA TGA
- Washington, DC EMA
- Texas, Part B

Housing **Status:** Currently unfunded support service

Other Funding (based on 2023 Needs Assessment): HOWPA program $10,421, 280

HRSA PCN #16-02 Definition (pg.18-19)

Description:

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.
HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Other Sample Services:

- Atlanta, GA EMA
- Texas, Part B
- Florida, Part B
- Maricopa, AZ EMA

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

AGENDA

I.	Call to Order	Dr. Mary Jo Trepka
II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 11, 2024	All
VII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Medical Care Subcommittee Items	Dr. Mary Jo Trepka
	• Vacancies	Marlen Meizoso
VIII.	Standing Business	
	• Service Standards	All
	• Service Categories Development Continued	All
	• Service Definitions Review: Food Bank	All
	• Vice Chair Position	All
IX.	New Business	
	• Clarification of Prior Motion: Date	All
	• Service Definition Review: Outreach and Health Insurance	All
	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Mary Jo Trepka

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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FOOD BANK

(Year 3~~3~~4 Service Priority: #~~7~~5 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~~4~~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~~4~~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:

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) (effective as of April 1, 2024).

~~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 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-

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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).

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

AGENDA

I.	Call to Order	Dr. Mary Jo Trepka
II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 11, 2024	All
VII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Medical Care Subcommittee Items	Dr. Mary Jo Trepka
	• Vacancies	Marlen Meizoso
VIII.	Standing Business	
	• Service Standards	All
	• Service Categories Development Continued	All
	• Service Definitions Review: Food Bank	All
	• Vice Chair Position	All
IX.	New Business	
	• Clarification of Prior Motion: Date	All
	• Service Definition Review: Outreach and Health Insurance	All
	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Mary Jo Trepka

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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 should not supersede the primary goals of connecting newly diagnosed (newly identified)

clients to care, as well as locating and reconnecting to the service system those clients who have been lost to care or who are at risk of becoming lost to care

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 1/12th 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.

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

(Year 3~~2~~4 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 202~~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 202~~2~~4 and 202~~3~~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 may lose access to Wraparound assistance with allowable copayments and deductibles from the Ryan White Part A Program.

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-threeseven- **(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. Health Insurance Deductibles

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.

Scan to access meeting documents.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Care and Treatment
Thursday, February 8, 2024

10:00 a.m. – 12:00 p.m.

Behavioral Science Research
2121 Ponce de Leon Blvd, Ste. 240
Coral Gables, FL 33134

AGENDA

I.	Call to Order	Dr. Mary Jo Trepka
II.	Introductions	All
III.	Meeting Housekeeping	Marlen Meizoso
IV.	Floor Open to the Public	Dr. Mary Jo Trepka
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of January 11, 2024	All
VII.	Reports	
	• Recipients (Part A, Part B, ADAP, General Revenue)	All
	• Medical Care Subcommittee Items	Dr. Mary Jo Trepka
	• Vacancies	Marlen Meizoso
VIII.	Standing Business	
	• Service Standards	All
	• Service Categories Development Continued	All
	• Service Definitions Review: Food Bank	All
	• Vice Chair Position	All
IX.	New Business	
	• Clarification of Prior Motion: Date	All
	• Service Definition Review: Outreach and Health Insurance	All
	• Meeting Location	All
X.	Announcements and Open Discussion	All
XI.	Next Meeting: **March 14, 2024** at **TBA**	Dr. Mary Jo Trepka
XII.	Adjournment	Dr. Mary Jo Trepka

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For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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