

**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2010-2011
(Year 20)**

**Section I –
Service Definitions**



***Miami-Dade County
Office of Grants Coordination***

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I. GENERAL REQUIREMENTS – All Service Categories

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

- A. Service Delivery Standards:** All providers will adhere to the *Ryan White Program System-wide Standards of Care* and other applicable standards and guidelines that are relevant to individual service categories (i.e., *Ryan White Program Case Management Standards of Service*, Public Health Service Clinical Guidelines for the Treatment of AIDS-Related Disease, HAB HIV Core Clinical Performance Measures for Adults/Adolescent Clients etc.), as may be amended. Please refer to Section III of this book for details.
- B. Client Eligibility Criteria:** Providers must document that clients who receive Ryan White Program-funded services have a Ryan White Program Certified Referral or have documentation on file that the client:
- Is HIV positive or has AIDS
 - Has a documented gross household income that does not exceed 400% of the 2010 Federal Poverty Level (FPL) for core services (see below for definition); (NOTE: the 2009 FPL guidelines will be used until the 2010 FPL guidelines are released in mid-March)
 - Income level caps for support services vary and can be found in the individual service definitions located in this book.
 - Although the Ryan White Program has no cash asset qualifications, providers are required to check the property tax page of the Miami-Dade County Tax Collector website (www.miamidade.gov/proptax/) to ensure that clients who have more than one property (i.e., additional income from rental property) have their gross household income adjusted accordingly.
 - Is a current, permanent resident of Miami-Dade County;
 - Is documented as having been properly screened for Medicaid, Medically Needy, Medicaid PAC Waiver, Medicare, other public sector funding, and private insurance, as appropriate. While clients qualify for and can access Medicaid, Medicaid Waiver, Medicare, other public funding, or private insurance for services, they will not be eligible for Ryan White Program-funded services, except for those services, tests, and/or procedures, etc. not covered by the other funding sources and related to the client's HIV disease.
 - The Ryan White Program is the payer of last resort; with the exception of client's who have Veteran's Administration benefits and are otherwise eligible for Ryan White Program services, and choose to access the Ryan White Program first.

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

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

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

- C. Core Services:** These services, as defined in the Ryan White HIV/AIDS Treatment Extension Act of 2009, include outpatient medical care; prescription drugs; oral health care; health insurance premium and cost-sharing assistance for low-income individuals; medical nutrition therapy; mental health services, substance abuse outpatient care; and medical case management, including treatment adherence services. Ryan White Program clients may access any of these services without restriction as long as Ryan White Program eligibility has been determined either via a Ryan White Program Certified Referral or an Out-of-Network (OON) referral, also known as the “General Certified Referral for Ryan White Program Services,” that is generated by a non-Ryan White Program case manager. An OON referral must be accompanied by appropriate Ryan White Program supporting documentation of client eligibility for services and this documentation must be kept in the client chart at the Ryan White Program referral site.
- D. Support Services:** These services, as defined in the Ryan White HIV/AIDS Treatment Extension Act of 2009, include outreach; medical transportation; legal services; food and meal programs; psychosocial support; and residential substance abuse treatment/counseling. Except in certain outreach scenarios (see revised Outreach Services Definition), clients may only receive these support services if they have a Ryan White Program Certified Referral or an OON referral. This is necessary to assure that clients are engaged in on-going medical care and treatment. Referrals must specify an end date that is detailed in each of the corresponding, specific service category definitions (e.g., food and meal programs – referral expires after 3 months; residential substance abuse treatment/counseling – after 4 months; and legal services – after 1 year).

E. Performance Improvement and Outcome Measures: All providers will develop internal performance improvement programs and collaborate with the Miami-Dade County Ryan White Program Quality Management Program contracted to Behavioral Science Research Corporation (BSR). Providers will be evaluated against the outcome measures contained in Miami-Dade County Professional Service Agreements (contracts), the Health Resources and Services Administration's "HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3," HAB Performance Measures for Medical Case Management and Oral Health Care, Ryan White Program Minimum Primary Medical Care Standards for Chart Review, Ryan White Program Oral Health Care Standards, and/or the Performance Improvement Plan (PIP) and its addenda. They will be responsible for collecting and reporting on specific data to measure performance, as detailed in the documents listed above.

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

F. Reporting: Providers must report monthly activity according to the recorded number of client visits, dates of services, type of procedures (if applicable), units of service provided, and unduplicated number of clients served. See individual service category definitions for additional reporting requirements, where applicable.

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

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

MAI funds are designated to reduce the HIV-related health disparities and improve the health outcomes for HIV+ minority populations such as Black/African Americans (including but not limited to Haitians), Hispanics, Native Americans, etc. The over-

arching purpose of the Minority AIDS Initiative is to achieve 100% access to quality care and 0% disparity in health outcomes.

Providers qualify as “Minority Community Based Organizations” by being a non-governmental agency serving a clientele that is composed of 85% or more of racial/ethnic minority populations.

In addition, per Federal requirements, organizations funded to provide MAI services must meet the following criteria:

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

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

III. REFERRAL REQUIREMENTS - All Ryan White Program-funded providers may accept Ryan White Program Certified Referrals for service if the referral is current, signed by the referring medical case manager, and indicates the referral’s end date, which may be different depending on the service category. The Ryan White Program Certified Referral verifies that all client eligibility documentation (HIV status, financial income level verification, and current permanent Miami-Dade County residency) and all required consents (Notice of Privacy Practices, SDIS Consent to Release and Exchange Information, and the Composite Consent) have been gathered by the referring Ryan White Program-funded medical case manager and can be found in the client chart at the referring agency’s location. Ryan White Program Certified Referral forms must be kept on file, in the client’s chart, at each site where a referral has been received. Failure of the referring agency to maintain appropriate eligibility documentation in the client chart is subject to corrective action and fiscal repayment to the County. The agency receiving a

Ryan White Certified Referral or an Out of Network (OON) referral must also maintain the actual referral or appropriate supporting documentation in the client chart.

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

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OUTPATIENT MEDICAL CARE (General HIV/AIDS Population & MAI)
(Year 20 Service Priority #1)

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

[IMPORTANT NOTE: Services are restricted to outpatient services only.]

I. Primary Care

1. **Primary Medical Care Definition and Functions:** Primary medical care includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe ARV therapy in an outpatient setting. Outpatient settings include clinics, medical offices, and mobile vans where clients in general do not stay overnight. Emergency room services are not considered outpatient settings, and are not covered. Inpatient services are also not covered. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care, as necessary.

If a phenotype lab test is needed, a *Ryan White Program Letter of Medical Necessity, completed by a physician, for Antiretroviral Phenotype Resistance Assays for Experienced Patients* is required. Note: the Virtual Phenotype test does not require a Letter of Medical Necessity.

Additionally, if the client is eligible for ADAP, the Trofile Assay (for Maraviroc resistance) and the Abacavir HLA-B*5701 hypersensitivity test will not be reimbursed by the Ryan White Program. Medical providers and/or medical case managers must verify and document on the Ryan White Program Letter of Medical Necessity that the client has been thoroughly screened for ADAP eligibility and been denied ADAP enrollment before they access Ryan White Program funding for any of these services. Utilization of these tests will be monitored quarterly.

2. **Client Education:** Providers of primary 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 care services are responsible for assisting clients with adherence in the following ways:
 - Adherence with medication regimens in order to reduce the risk of developing and spreading a resistant virus and to maintain health;
 - Taking medications as prescribed and following recommendations made by physicians, nutritionists, and pharmacists;
 - Client involvement in the development and monitoring of treatment and adherence plans; and
 - Ensuring immediate follow-up with clients who miss their prescription refills and/or who experience difficulties with adherence.

4. **Coordination of care:** Providers of primary 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 care services may include:

- Respiratory therapy needed as a result of HIV infection; and
- Consumable medical supplies and durable medical equipment (DME) for the administration of medications that are not available through prescription drug services and that have been prescribed or ordered by the client's primary care physician. Providers must submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Providers may request approval of a supplemental list for items that have a HCPC code, but do not have a corresponding Medicare or Medicaid rate.

II. Outpatient Specialty Care

- 1. Specialty Care Definition and Functions:** This service covers short-term ambulatory treatment of specialty medical conditions and associated diagnostic procedures for HIV+ clients who are referred by a primary care provider. Specialty medical care includes outpatient rehabilitation, dermatology, oncology, optometry, ophthalmology, obstetrics and gynecology, urology, podiatry, pediatrics, rheumatology, physical therapy, occupational therapy, speech therapy, respiratory therapy, psychiatry, nutritional assessments or counseling, and other specialties as related to the client's HIV diagnosis.

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

- 2. Client Education:** Providers of specialty care services will be expected to provide the following basic education as part of client care:
- Basic education to clients on various treatment options offered by the specialist;
 - Taking medications pertaining to specialty care treatment as well as adhering to treatment recommendations made by the primary care physician; and
 - Educating clients about HIV/AIDS and its relationship to the specialty care service being provided.
- 3. Coordination of Care:** The specialist must communicate, as appropriate, with the primary care physician and client for results, follow-up, and/or to re-evaluate the client in order to coordinate treatment.

4. Additional specialty care may include:

- Consumable medical supplies and durable medical equipment (DME) for the administration of medications that are not available through prescription drug services and that have been prescribed or ordered by the client's specialist. Providers must also submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Providers may request approval of a supplemental list for items that have a HCPCS code, but do not have a corresponding Medicare or Medicaid rate.

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

- Providers must offer and post walk-in hours to ensure maximum accessibility to outpatient medical care;
- Providers must demonstrate a history and ability to serve Medicaid eligible clients; and
- Providers must ensure that medical care professionals have a minimum of three (3) years of experience treating HIV clients or have served a high volume of HIV+ clients in the past year.

Additionally, for outpatient specialty care only:

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

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

- Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses (as amended and current)
- HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Groups 1, 2, and 3
- Minimum Primary Medical Care Standards for Chart Review

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

- Reimbursements for medical procedures and follow-up contacts to ensure client's adherence to prescribed treatment plans will be no higher than the rates found in the "2010 Florida Medicare Part B Physician Fee Schedule (Participating, Locality 04), text file dated January 15, 2010."
- Reimbursements for medical procedures performed at Ambulatory Surgical Centers (ASC) will be no higher than the rates found in the "2010 Florida Medicare Part B ASC Fee Schedule, by HCPCS Codes and Payment Rates, revised December 31, 2009." (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 2010, dated January 2010." (Applies only to organizations with on-site or affiliated outpatient hospital centers).
- Evaluation and management visits and psychiatric visits will be reimbursed at rates no higher than the Medicare "allowable" rates times a multiplier of up to 1.5.
- Reimbursements for lab tests and related procedures will be based on rates no higher than those found in the "2010 Medicare Clinical Diagnostic Laboratory Fee Schedule, for Florida (FL), revised December 29, 2009." If the client is eligible for ADAP, that program should be accessed for genotype and phenotype testing. A Letter of Medical Necessity is required for Ryan White Program reimbursement for phenotype tests (not including virtual phenotype tests), as well as for the Trofile Co-Receptor Tropism Assay.
- Reimbursements for injectables will be based on rates no higher than those found in the "2010 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, dated January 20, 2010 (payment limit column)."
- Reimbursement for consumable medical supplies will be based on rates no higher than those found in the "Medicare Durable Medical Equipment and Supplies Revised 2010 Fee Schedule, for Florida (FL), dated December 10, 2009." In the absence of an existing Medicare rate, reimbursement for consumable medical supplies will be based on rates no higher than those found in the most current Florida Medicaid's Durable Medical Equipment for All Medicaid Recipients, as of March 1, 2010.

- No multiplier will be applied to reimbursement rates for laboratory tests and related procedures, for non-evaluation and management procedures, for injectables, supplemental procedures, or for consumable medical supplies.

Additional rules for reimbursement:

- Medical procedures and consumable medical supplies excluded from the Medicare (or Medicaid, for consumable supplies) Fee Schedules may be provided on a supplementary schedule. 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.
- E. Additional Rules for Reporting:** Provider monthly reports for consumable medical supplies must include the number of clients served, medical supply distributions per client, and dollar amounts spent per client.
- 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.

PRESCRIPTION DRUGS (General HIV/AIDS Population & MAI)
(Year 20 Service Priority #2)

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

[IMPORTANT NOTE: Services are restricted to outpatient services only. Inpatient and emergency room prescription drug services are not covered.]

1. Medications Provided: This service pays for injectable and non-injectable **Prescription Drugs**, pediatric formulations, and non-prescription nutritional supplements, appetite stimulants, and/or related supplies for the administration of medications. Medications are provided in accordance with the most recent release of the Ryan White Program Prescription Drug Formulary and also include assistance for the acquisition of non-Medicaid, Medicare Part D, or ADAP reimbursable drugs, as well as the purchase of consumable medical supplies that are required to administer prescribed medications. The Ryan White Program Prescription Drug Formulary is subject to change due to guidance from HRSA, the federal granting agency, and/or the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

2. Client Education and Adherence:

- Providers are expected to educate clients on the importance of adhering to their medication regimen with the objectives of reducing the risk of developing and spreading a resistant virus, and to ensure a healthy life for the client.
- Providers are expected to offer basic education to clients on various treatment options, including information about state of the art combination drug therapies.
- Clients must be encouraged to take medications as prescribed, as well as to follow the recommendations made by physicians, nutritionists, and pharmacists regarding medication management.

3. Coordination of Care:

- Providers must maintain appropriate contact with other caregivers (i.e., the client's medical case manager, physician, nutritionist, counselor, etc.) and with the client in order to monitor that the client adheres to their medication regimen; and ensures that the client receives coordinated,

interdisciplinary support for adherence, and assistance in overcoming barriers to meeting treatment objectives.

- Providers will be expected to immediately inform medical case managers when clients are not adhering to their medication regimen (i.e., the client misses prescription refills or is having other difficulties with treatment adherence).
- Providers are expected to ensure immediate follow-up with clients who miss their prescription refills and/or who experience difficulties with treatment adherence.

B. Program Operation Requirements:

- Providers are encouraged to provide county-wide delivery. However, **Ryan White Program funds** may not be used to pay for the delivery of medications or consumable medical supplies unless one of the following conditions is met by the client, is documented by the client's physician, and said documentation is maintained in the client's chart:

(1) The client is permanently disabled (condition is documented once);

(2) The client has been examined by a physician and found to be suffering from an illness that significantly limits his/her capacity to travel [condition is valid for the period indicated by the physician or for sixty (60) days from the date of certification].

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

- Providers must specify provisions for home delivery of medications and related supplies and equipment for eligible Ryan White Program clients who require this service.
- Provision of this service may not be limited to an agency's own clients unless 340B covered entity status requires this restriction. **However, if the provider is a 340B covered entity and the client is enrolled in the state ADAP Program, that client is eligible for 340B pricing for prescriptions not covered by the ADAP formulary regardless of whether or not the client is the agency's own client.**
- The service provider must be linked to an existing medical case management system through agreements with multiple medical case management providers. Providers are contractually required to enter into formal referral agreements that detail responsibilities of both parties and penalties for not complying with the referral agreement.

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

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

- Where applicable, providers will be reimbursed for prescription drugs based on the Public Health Services (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 that will be added to the PHS price. (For example, if the PHS price of a prescription for Ritonivir is \$50.00, and your proposed flat rate is \$5.00 then the straight rate is equal to \$55.00.) An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form.
- Where applicable, providers will be reimbursed for prescription drugs based on the Average Wholesale Price (AWP) of the prescription provided to the Ryan White client, minus a per-prescription discount rate. Total costs should include the cost of home delivery, as allowable. Providers must stipulate the discount rate that they will be subtracting from the AWP, which may not be less than 10%. Please note that providers may utilize a discount rate higher than 10% (i.e., AWP - 14%). (For example, if the AWP of a prescription for Ritonivir is \$100.00, and your proposed discount rate is 10%, then the straight rate is equal to \$90.00.) An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form.
- Providers will be reimbursed for consumable medical supplies related to the administration of medications based on rates not to exceed the rates found in the "Medicare Durable Medical Equipment and Supplies Revised 2010 Fee Schedule, for Florida (FL), dated December 10, 2009." In the

absence of an existing Medicare rate, reimbursement for consumable medical supplies will be based on rates no higher than those found in the most current Florida Medicaid's Durable Medical Equipment for All Medicaid Recipients, as of March 1, 2010. No multiplier will be applied to Medicare or Medicaid rates for consumable medical supplies. Providers must also submit to the County a list of the medical supplies that will be available to the HIV+ client. This list must identify each medical supply item using the appropriate Healthcare Common Procedure Coding System (HCPCS) code, along with the corresponding Medicare or Medicaid rate. Consumable medical supplies excluded from Medicare and Medicaid may be submitted to the County for approval of a supplementary flat rate fee schedule only.

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

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

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

- Prescribed medications that are included in the most recent release of the Ryan White Program Prescription Drug Formulary. This formulary is subject to periodic revision;
- Medications, nutritional supplements, appetite stimulants, or vitamins that have been prescribed for the client by his/her physician; and

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

Medications:

- **Aptivus** (Tipranavir)
- **Fuzeon** (Enfuvirtide)
- **Neupogen** (Filgrastim)
- **Nutritional Supplements** (for Adults and Children)
- **Procrit** (Epoetin Alpha)

- **Roxicodone** (Oxycodone) **and Percocet** (Oxycodone/APAP)
- **Selzentry** (Maraviroc)
- **Sporanox** (Itraconazole)

Test:

- **Trofile Co-Receptor Tropism Assay** (required to prescribe Selzentry (Maraviroc))

Please Note: Medical Case Managers must work with clients to diligently and in a timely manner to explore all payer options and evaluate the client's best option to ensure that prescription medications are covered by the appropriate program. For Medicare Part D recipients, any client whose gross household income falls below 135% of the 2010 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 136% and 150% of the FPL must be enrolled in the ADAP Wrap Around Pilot Project (AWAPP). 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 fall into the "donut hole," must be referred to the ADAP Program, if eligible, in order to apply for an insurance waiver.

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MEDICAL CASE MANAGEMENT (General HIV/AIDS Population & MAI)
(Year 20 Service Priority #3)

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

Medical case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring, and evaluating available options and services. Medical case management addresses situational needs and promotes continuity of care for the client. Medical case management is predicated upon client empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services. Medical case management addresses the needs of both individual and family entities, including both adults and children.

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

MEDICAL CASE MANAGEMENT COMPONENTS

- I. Medical Case Management:** Medical case managers must be knowledgeable about the diversity of programs and be able to develop service plans from various funding streams. They are responsible for helping clients access needed services, not just Ryan White Program-funded services.

Medical case managers are responsible for performing the following functions: 1) conducting a full assessment of the client's medical, financial, social, and other needs (initial intake); 2) developing care plans including coordination and follow-up of medical treatment; 3) managing and coordinating services (referrals, assisting with initial appointments, and coordinating services identified in the care plan, etc.); 4) monitoring client adherence to the care plan and medication regimens, as well as ensuring that service providers involved in the client's care are rendering services as requested; 5) evaluating services provided to the client by all funding sources to determine consistency with the established care plan; 6) reassessing and revising the care plan every six months for active clients, unless otherwise specified; 7) conducting secondary prevention; and 8) closing cases and documenting the reason for case closure for clients that have not been seen in over 12 months.

II. Peer Education and Support Network (PESN): At the option of the client, the medical case management agency will assign an HIV+ "Peer" (i.e., PESN, Case Aide, Peer Educator, Peer Navigator) to provide "peer support," including client orientation and education about health and social service delivery systems. The HIV+ Peer may assist with initial client intake, paperwork and applications for financial and medical eligibility, educating new clients on the process of accessing core and support services, as well as accompanying clients to initial appointments for medical care and other services. The HIV+ Peer may also make phone calls to clients for the purpose of reminding them of medical appointments, in order to improve the client's attendance and reduce no-shows.

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

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

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

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

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

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

Medical case management providers are expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and to ensure that immediate follow-up is available for clients who miss their prescription refills and/or who experience difficulties with adherence or medical visit attendance. Medical case management providers must

ensure that the client is knowledgeable about HIV/AIDS; understands CD4 count, viral load, adherence and resistance concepts; understands the reason for treatment; identifies and addresses the possible factors or barriers affecting treatment adherence; and understands his/her treatment regimen to the best of the client's ability.

1. Medical Case Manager Qualifications:

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

2. Provider Requirements:

- a) **Contractual.** Providers will be expected to report to Miami-Dade County the following:
- An explanation of the training that will be offered to case management staff, including "peers," and that should include cultural sensitivity issues.
 - An explanation of how client's adherence to treatment will be monitored and how adherence problems will be identified and resolved;
 - An explanation of how the provider will serve clients who speak English, Spanish, and Creole or who have limited language proficiency. **Medical case management providers must budget for the following expenses or otherwise accommodate client needs for: American Sign Language interpreter, foreign language interpreter, Braille, and other materials to accommodate clients with disabilities, limited English language proficiency, and/or low literacy levels.**
 - A description of linkage agreements in place with other HIV/AIDS service providers.
- b) **Required Forms.** Medical case management staff will utilize Ryan White Program standardized forms, as developed by the Miami-Dade HIV/AIDS Partnership and the County, for all medical case management functions.
- c) **Referrals.** All referrals made by Part A or MAI-funded medical case managers to Ryan White Program services must be made utilizing the Ryan White Program Certified Referral process,

which is available through the Service Delivery Information System (SDIS). Referrals cannot be made for services not documented in the client's plan. However, in the case of emergency, care plans may be amended within two (2) business days to allow for the referral. Referrals for non-Part A or non-MAI services and by non-Part A or non-MAI funded case managers will use the Out-of-Network (OON) general certified referral form available from the County's Office of Grants Coordination – Ryan White Program. The OON referral must be accompanied by appropriate supporting documentation and signed consents.

- d) **Caseload.** Medical case managers should have a caseload of no more than 70 active clients. Clients limited to only "situational needs" should not be included in the "active" caseload count.
- e) **Peer schedules.** Providers are reminded that some "peer" workers may be eligible for disability income and/or other supplemental income. Consequently, a part-time work schedule should be well-planned to meet the needs and benefits of the peer employee.

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

C. Rules for Reimbursement: The units of service used for medical case management and PESN reimbursements are as follows.

1. *Medical Case Management Services:*

- *Face-to-Face encounter (FFE):* quarter-hour units (15 minutes), at rates not to exceed \$14.00 per unit, defined as any time the medical case manager has direct contact with the client in person. In consultations with a child and one or more adults, encounters are billed for one family member only who must be HIV+ and eligible for Ryan White Program-funded services.
- *Other encounter:* quarter-hour units (15 minutes), at rates not to exceed \$14.00 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone (TEL) contacts with the client and/or his/her representatives; development of a care plan or progress note documentation (DOC); travel time (with documentation in the client chart of the reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan; collateral (COL) contacts with other providers or representatives on behalf of the client, referral activities (setting up appointments,

arranging transportation, etc.), or treatment planning or consultation meetings held on behalf of a client; encounters with or on behalf of the client for the purpose of enrolling or re-certifying the client in the AIDS Drug Assistance Program (ADAP); and for time spent attending authorized Ryan White Program trainings (TRN), such as monthly case management and case management supervisor trainings, Service Delivery Information System trainings, and quarterly Ryan White Program Provider Forums. (NOTE: The TRN code may not be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code cannot be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, or other employer-required training.) Travel time is not included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code.

- *Case Manager Supervisor encounters: (may only be billed by documented Case Manager Supervisors)* quarter-hour units (15 minutes), at rates not to exceed \$14.00 per unit, defined as services associated with chart review (REV) processes to ensure that case management staff are in compliance with the *Ryan White Program Case Management Standards of Service* or quarter hour units (15 minutes) consulting with case management staff (CON) on client, supervisory, or quality management issues. Case Manager Supervisors may also use the TRN code, using the guidelines specified above.

2. *Peer Education and Support Network (PESN) Services:*

- *Face-to-Face encounter (FFE):* quarter-hour units (15 minutes), at rates not to exceed \$7.50 per unit, defined as any time the "Peer" has direct contact with the client in person.
- *Other encounter:* quarter-hour units (15 minutes), at rates not to exceed \$7.50 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone contacts (TEL) with the client and/or his/her representatives; progress note documentation (DOC), travel time (with documentation in the client chart of the reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan; or collateral contacts (COL) with other providers or representatives on behalf of the client. Peer Educators may also use the ADAP and TRN codes where applicable, using the guidelines specified above.

3. Providers are required to document in the client's chart each unit of service performed (including the type of encounter and length of time spent) as face-to-face encounters or on behalf of a client. Units of service must be documented and reported separately for PESN and medical case management services.
 4. Client eligibility screening for voucherable services is billable as a unit of service depending on the amount of time spent with the client. Costs related to the distribution of voucher services should be covered under the dispensing charge allowed for handling of vouchers under the voucherable service category (i.e., transportation EASY Tickets).
- D. Additional Rules for Reporting:** Providers of PESN and medical case management services must report, separately, their monthly activities according to quarter-hour (15 minutes) "Face-to-Face" encounters and quarter-hour (15 minutes) "Other" encounters. In addition, providers must report the number of unduplicated clients served.

ORAL HEALTH CARE
(Year 20 Service Priority #4)

This service includes routine **Oral Health Care** examinations and prophylaxis, X-rays, fillings, prosthetics, treatment of gum disease, oral surgery, and instruction on maintaining oral health.

- A. Program Operation Requirements:** Providers of primary or specialty outpatient care wishing to include oral health care services under their scope of operations must either demonstrate on-staff clinical capacity or have letters of intent from specific oral health care providers to provide these services under subcontract.

Provision of oral health care services for any one client is limited to an annual cap of \$3,000 per the Ryan White Part A Fiscal Year (March 1, 2010 through February 28, 2011). Very limited exceptions to the annual cap may be approved by the County, with consultation from the Miami-Dade HIV/AIDS Partnership's Oral Health Care Subcommittee as needed, on a case-by-case basis for the provision of preventative oral health care services only.

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

- B. Additional Service Delivery Standards:** Providers of this service will adhere to the *Ryan White Program System-wide Standards*. (Please refer to Section III of this book for details.) Providers will be required to demonstrate that they will adhere to generally accepted clinical guidelines for oral health care treatment of HIV and AIDS-specific illnesses.
- C. Rules for Reimbursement:** Providers will be reimbursed for all routine and emergency examination, diagnostic, prophylactic, restorative, surgical and ancillary oral health care procedures, as approved by the Miami-Dade HIV/AIDS Partnership and included in the most current Ryan White Program Oral Health Care Formulary, using the 2009-2010 American Dental Association Current Dental Terminology (CDT 2009-2010), codes for dental procedures, at rates that represent a constant multiple of the most current State of Florida Medicaid Dental

Services Coverage and Limitations Handbook reimbursement rates for each procedure, last updated July 21, 2009. The constant multiple may not exceed 3.0 times this Medicaid Dental Services rate. Providers must stipulate the multiplier they will be applying to the Medicaid Dental Services reimbursement rates during the program year. An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding price form. Provider negotiated Medicaid rates will not be accepted.

Necessary tests or procedures that have a CDT 2009-2010 procedure code and are excluded from Medicaid must be submitted to the County for approval of a supplementary fee schedule. A flat rate for each procedure and a detailed description of the procedure and a cost justification must be included in the request for approval.

- D. Children's Eligibility Criteria:** Providers must document that HIV+ children who receive Part A-funded oral health care services are permanent residents of Miami-Dade County and have been properly screened for Medicaid and other public sector funding (i.e., the Medically Needy Program), as appropriate. While children qualify for and can access Medicaid or other public sector funding for oral health care services, they will not be eligible for Ryan White Part A-funded oral health care services, except those tests or procedures excluded by Medicaid.
- E. Ryan White Program Oral Health Care Formulary:** Ryan White Part A funds may only be used to provide oral health care services that are included in the most recent release of the Ryan White Program Oral Health Care Formulary. The Formulary is subject to periodic revision.

MENTAL HEALTH THERAPY/COUNSELING

(Year 20 Service Priority #5)

This service offers non-judgmental psychological treatment and counseling services including individual, group, and crisis intervention counseling provided by licensed mental health counseling professionals. **Mental Health Therapy/Counseling** services may be delivered in individual or group settings. **Please note that Ryan White Program funds may not be used for bereavement support for uninfected family members or friends.**

Mental health therapy/counseling services reimbursed under Part A of the Ryan White Program are limited to conditions stemming from and treated within the context of the client's HIV/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.

NOTE: All initial assessments and assignments to subsequent therapy/counseling levels will be done by a licensed Level I or Level II professional.

- **Mental Health Therapy/Counseling (Level I)** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess *postgraduate degrees* in psychology or counseling (PhD, EdD, Psy.D) and must be *licensed by the State of Florida* as a LCSW, LMHC, or LMFT to provide such services.
- **Mental Health Therapy/Counseling (Level II)** - Licensed Professional Mental Health Counseling: This service includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess *Master's degrees* in psychology, psychotherapy or counseling (MS, MA, MSW, or M.Ed.), and must be *licensed by the State of Florida* as a LCSW, LMHC or LMFT to provide such services.

Mental Health Therapy/Counseling Components:

Counseling services (**Level I**) provided to clients by licensed professionals will include psychosocial assessment and evaluation, testing, diagnosis, treatment planning with written goals, crisis counseling, periodic reassessments, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to HIV/AIDS clients such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing and harm reduction strategies to their clients, if deemed clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term

[individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

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

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

- A. Program Operation Requirements:** Staff must demonstrate knowledge of HIV disease, its psychosocial dynamics and implications, including cognitive impairment, and generally accepted treatment modalities and practices. Services may be delivered to non-HIV+ family members (as defined by the client) only if the HIV+ client is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of support group participants to counselors may not be lower than 3:1 and may not be higher than 15:1. One visit is equal to one half-hour counseling session.
- B. Additional Service Delivery Standards:** Level I and Level II providers must adhere to generally accepted clinical guidelines for psychological treatment of persons with HIV/AIDS-illnesses. (Please refer to Section III of this book for details.)
- C. Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half-hour counseling session not to exceed \$32.50 per unit for Level I individual counseling; \$35.00 per unit for Level I group counseling; \$32.50 per unit for Level II individual counseling; and \$35.00 per unit for Level II group counseling. Reimbursement for individual counseling units are calculated for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are calculated for

the counselor that provided the group therapy (i.e., number of group counseling units per counselor).

- D. Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a one-half-hour counseling session and the unduplicated number of clients served. Providers will report individual and group activity separately for Level I and Level II mental health therapy/counseling services.

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**SUBSTANCE ABUSE COUNSELING -
RESIDENTIAL AND OUTPATIENT TREATMENT**
(General HIV/AIDS Population & MAI for Residential Treatment)
(Year 20 Service Priorities #6 and #8)

Two types of **Substance Abuse Treatment/Counseling** programs are included under this service category, **Residential and Outpatient**. Services must be provided to HIV+ clients in state-licensed treatment facilities, and should be limited to the pre-treatment program of recovery readiness and relapse, as well as harm reduction, conflict resolution, anger management, relapse prevention, family group and intensive counseling to reduce depression, anxiety and other related disorders, drug-free treatment and treatment for alcohol and other drug addictions.

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

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

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

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

Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV+ client is also being served. Providers are encouraged to offer program services to families without separating the family unit. If the client is participating in a residential treatment program, the client's family member may visit the facility and participate in the counseling sessions, but the family member may not physically live in residential treatment with the client during the treatment process. A family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.A. of this service definition on the following page for details). *Note: For the purpose of this service, family members are defined as those individuals living in the same household as the client.*

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

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

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

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

Residential and outpatient substance abuse providers must coordinate billing so that outpatient counseling services provided as a result of a referral by a residential facility are only reimbursed once as part of the outpatient facility's billing.

I. Substance Abuse Counseling – Residential Treatment (Priority #6)

This program offers substance abuse treatment, including alcohol addiction and/or legal and illegal drugs, and counseling to HIV+ clients in state-licensed treatment facilities. Residential substance abuse treatment provides room and board, substance abuse treatment, including specific HIV counseling, in a secure, drug-free, state-licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Ryan White Program funds may not be used for hospital inpatient detoxification. All clients must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of substance dependence.

Residential treatment programs shall comply with the following requirements:

B. Rules for Reimbursement: The unit of service for reimbursement of substance abuse counseling - residential treatment is a *client-day* of care up to a maximum amount of \$125.00 per day. (NOTE: Use of the maximum per day rate requires prior approval from the Miami-Dade County Office of Grants Coordination – Ryan White Program.) **Under no circumstance may clients be enrolled in any Ryan White Program-funded residential substance abuse treatment program for longer than 120 days within a twelve-month period. Twelve months begins on the first day of a client's residential treatment. NO EXCEPTIONS. The length of stay for existing clients will be closely monitored by the County's Office of Grants Coordination – Ryan White Program.**

C. Additional Rules for Reporting: Monthly activity reporting for residential substance abuse treatment is per *client-day* of care and number of unduplicated clients served. Providers will indicate in the SDIS the client's disposition after residential substance abuse treatment services has

ended (e.g., treatment completed, client referred to outpatient substance abuse counseling, client withdrew from treatment, etc.).

- D. Linkage/Referrals:** Providers of residential substance abuse treatment must document the client's progress through the treatment program, maintain linkages with one or more outpatient facilities and appropriate community services, including 12-step programs, and be able to refer or place clients in an outpatient program, in collaboration with the client, his/her medical case manager, and the primary care physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving medical case management services; if not, the provider must seek enrollment of the client in a medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the medical case management provider must be established in order to ensure coordination of services while the client remains in treatment. **Residential substance abuse providers must notify the client's medical case manager upon the client's release, completion of treatment, and/or relapse.** *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.
- E. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation including all required consent forms and Notice of Privacy Practices) is required for this service. Clients receiving Ryan White Program Part A-funded residential substance abuse counseling/treatment must be documented as having a gross household income below 300% of the 2010 Federal Poverty Level (FPL).

II. Substance Abuse Counseling - Outpatient Treatment (Priority #8)

This program provides regular, ongoing substance abuse monitoring and counseling on an individual and group basis in a state-licensed outpatient setting. Providers of this service must specify the maximum number of clients expected to be enrolled in a group counseling session. The minimum amount of group participants is three (3) Ryan White clients per group and should be no higher than fifteen (15) persons per group. The ratio of support group participants to counselors should be no higher than 15:1. One unit is equal to one half-hour counseling session.

- **Substance Abuse Counseling (Level I) - Professional Substance Abuse Treatment.** This service includes *general and intensive* substance abuse therapy and counseling (individual, family, and group) provided by trained mental health or certified addiction professionals. Direct service providers must possess at least *postgraduate degrees* in the appropriate

counseling-related field, and preferably, be a *certified addiction professional (CAP)*.

- **Substance Abuse Counseling (Level II) - Counseling and Support Services.** This service includes supportive and crisis substance abuse counseling by trained and supervised counselors, peers, and facilitators. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Non-certified personnel providing this service will be supervised by professionals with appropriate Level I substance abuse counseling credentials.

- B. Additional Service Delivery Standards:** Providers of these services will also be required to adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS. (Please refer to Section III of this book for details.)

- C. Rules for Reimbursement:** Reimbursement for individual and group therapy will be based on a half hour counseling session not to exceed \$30.00 per unit for Level I individual counseling; \$34.00 per unit for Level I group counseling; \$27.00 per unit for Level II individual counseling; and \$30.00 per unit for Level II group counseling. Reimbursement for individual sessions is calculated for each client and/or family member(s) receiving the therapy, whereas, reimbursement for group sessions are calculated for the counselor that provided the group therapy. Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV+ client is also being served. The HIV+ client must be currently receiving such services; and preferably, but not necessarily, the family member may be served on the same day as the client.

- D. Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group therapy is a *one half-hour counseling session* provided to the client and the number of unduplicated clients served. Providers must also report, on a monthly basis, the number of group counseling units provided by each counselor.

- E. Linkage/Referrals:** Providers of outpatient substance abuse treatment must document the client's progress through the treatment program, maintain linkages with one or more residential facilities, appropriate community services, including 12-step programs, and be able to refer or place clients in a residential program, in collaboration with the client, his/her medical case manager, and primary care physician when that is found to be appropriate. Providers are required to determine if the client is currently receiving medical case management services; if not, the provider

must seek enrollment of the client in a medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the medical case management provider must be established in order to ensure coordination of services while the client remains in treatment. *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.

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INSURANCE SERVICES
(Year 20 Service Priority #7)

There are three types of assistance under this service category: **AIDS Insurance Continuation Program (AICP), Insurance Deductibles, and Prescription Drug Co-Payments.**

I. AIDS Insurance Continuation Program

This program provides assistance to clients who already have private health insurance but are not financially able to pay the premiums. This program does not provide new health insurance policies to eligible clients; it allows them to continue with their current insurance carrier. This program does not include coverage of disability or life insurance payments. The maximum amount of assistance a client may receive each month is \$750.00 (seven hundred fifty dollars) towards their monthly insurance premium. The Ryan White Program will be able to assist the client in making back payments of premiums as long as the insurance policy has not been terminated. Assistance may also be provided to facilitate conversion of group coverage (i.e., COBRA) to an individual insurance policy.

The Ryan White Part A Program supplements the State of Florida's AICP when the primary funding sources (Part B and Florida General Revenue) exhaust their funds. Ryan White Part A Program support depends on the amount allocated to this service. This service description covers only those services paid for by Ryan White Part A funds.

- A. Program Operation Requirements:** Providers may not reimburse clients directly for their premium expense.

Providers are required to inform clients of their rights regarding insurance coverage and to ensure they use their private health insurance to obtain medical care, prescription drugs, and other treatment. Clients will not be eligible for Ryan White Part A-funded services if such services are available under their existing health insurance, private or public.

- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended per insurance premium plus a dispensing rate of \$15 per month per premium.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *expended per insurance premium per client.*

- D. Special Client Eligibility Criteria:** Clients receiving Part A assistance for this service must also: 1) have active health insurance under a group, individual, or COBRA policy; and 2) be willing to sign all required forms and provide all requested eligibility information. A complete financial assessment and disclosure are required.

II. Insurance Deductibles

- A. Program Operation Requirements:** The goal of this program is to maintain a client's private health insurance coverage, thereby minimizing the client's reliance on the Part A Program for services. Under no circumstances shall payment be made directly to recipients of this service. The maximum amount of assistance a client may receive annually is \$2,500. A complete financial assessment and disclosure are required.
- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per deductible plus a dispensing rate*.
- C. Units of Service for Reporting:** Monthly activity reporting for this service must be in dollars expended *per deductible per client*. The service provider must also report the number of unduplicated clients served each month and the dollars spent per client.

III. Prescription Drug Co-Payments and Co-Insurance

- A. Program Operation Requirements:** This type of assistance is available to privately insured clients who are required to pay a co-payment for their medications. The pharmaceutical provider will bill the insurance carrier for a portion of the cost of the prescription plus the dispensing fee and Part A will cover the remaining portion of the cost for clients who meet Part A eligibility criteria. Assistance for both co-insurance and co-payments is restricted to those medications on the currently approved Ryan White Program Prescription Drug Formulary. A complete financial assessment and disclosure are required. A Physician's prescription is also required.
- B. Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per co-payment plus a flat fee dispensing rate*.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per co-payment per client*.

Please Note: Medical case managers and insurance enrollment specialists must work with clients to diligently and in a timely manner explore all insurance options and evaluate the client's best option to ensure that deductibles and co-payments are reasonable. For Medicare Part D recipients, any client whose gross household income falls below 135% of the 2010 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 136% and 150% of the FPL must be enrolled in the ADAP Wrap Around Pilot Project (AWAPP). 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 fall into the "donut hole," must be referred to the ADAP Program in order to apply for an insurance waiver.

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OUTREACH SERVICES
(General HIV/AIDS Population & MAI)
(Year 20 Service Priority #9)

I. Definition and Purposes of Outreach Services

Ryan White Program outreach services target HIV positive clients in need of assistance accessing HIV care and treatment who are:

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

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

Once an HIV+ lost-to-care or at risk of being lost-to-care client is located or an HIV+ client newly diagnosed and/or never in care is located, an SDIS referral must be made to a medical case manager, medical provider, residential substance abuse program, or other core service provider of the client's choice. The outreach worker may assist the client in obtaining necessary documentation to receive services and must 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 care and treatment.

Referrals to Ryan White Program Part A or MAI-funded outreach services may only be initiated if there is a valid outreach-specific consent signed by the client and filed in the client's chart.

A. 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 repeated attempts to contact the client by phone and mail without success, may refer the case through an SDIS certified referral to an outreach worker. A Physician may immediately and directly request outreach assistance for a client who meets any of the conditions indicated directly below in Section A. 2., or similar circumstances (e.g., abnormal lab results, etc.). Such circumstances must be clearly documented in the client's chart and indicating that the assistance of an outreach worker was

requested (i.e., the physician writes a prescription for the needed outreach service and documents such in the client's chart). 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 of at least three (3) repeated attempts by the medical case manager, pharmacy staff, or jail linkage/prison re-entry coordinator to contact the client and the reason why the case is being referred to an outreach worker. A Ryan White Program Certified Referral with last known contact information on the client indicating the reason for the outreach referral must be provided to the outreach worker and be maintained in both agencies' client charts.

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

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.

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

1. Linkage agreements form the basis of collaborative relationships between providers. Outreach providers must have formal referral and linkage agreements with one or more of the eight (8) key points of entry to the

system of care listed below for the purpose of receiving referrals for HIV+ clients identified at key points of entry.

- STD clinics
- HIV counseling and testing sites
- hospitals/emergency room departments
- substance abuse treatment providers
- mental health clinics
- adult and juvenile detention centers
- jail and/or correctional facilities, including, but not limited to, re-entry programs
- homeless shelters

Linkage agreements must include outreach worker's contact information, work schedule availability, geographic areas of the County covered, and a description of outreach services offered. Clients referred from a key point of entry will be assisted to obtain necessary documentation for enrollment in the service system, will receive an SDIS referral to the core service provider of their choice, be accompanied to the initial appointment and be followed-up to ensure that they are connected to care.

C. One Time Referrals

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

D. Outreach Activities

1. Outreach workers may engage in the following activities, if documented and filed in the client's chart at the referring agency and at the receiving agency where applicable: 1) for their agency's own clients; 2) upon receipt of a Ryan White Program Certified Referral for a particular client, for whom the referring agency has a valid informed outreach-specific consent signed by the client and filed in the client's chart; 3) a prescription from a physician; or 4) by a letter or referral from a jail linkage or prison re-entry coordinator as indicated in Section A.1. above:

- obtain from the client all required consents for the outreach worker to access client-related information in the Ryan White Program's Service Delivery Information System (SDIS);
- conduct brief intakes for new clients and enter data into the SDIS outreach registration screen;
- review data in the SDIS for existing clients who are lost to care or are at risk of falling out of care;
- assess and document the client's barriers to accessing care; contact the service provider of the client's choice to coordinate appointments and obtain required documentation for services;
- accompany newly diagnosed, lost to care, or otherwise unconnected HIV+ clients to the initial physician appointment, medical case management appointment, and/or intake at a residential substance abuse facility of the client's choice 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;
- make home visits to meet with a client for the purpose of connecting them to care;
- as a safety issue, 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. 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 Service Delivery Information System (SDIS) the encounter should only be counted/recorded by the main outreach worker/agency that received the referral;
- provide education on available care and treatment options and services available to HIV+ individuals with the goal of directly empowering and enabling the client to access existing HIV/AIDS service programs, including Counseling & Testing sites;
- provide out-stationed linkage and coordination to care services at key points of entry, including but not limited to counseling and testing facilities and other facilities with high percents of HIV+ clients as identified by the counseling and testing facility and verified by the Ryan White Part A Program.

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

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

Ryan White Program outreach activities are not to be used for the recruitment of clients to the outreach worker's agency.

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

- name of outreach worker;
- name, signature, and consent of client;
- client's date of birth;
- client's gender;
- client's race and ethnicity;
- client's address or follow-up information;
- the 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;
- 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
- if lost to care or identified as at risk of being lost to care, a copy of the initiating agencies' referral to outreach;
- an individualized assessment of the client's barriers to care;

- documentation that explanation of service system and choice of provider agency were provided;
- a copy of an SDIS referral or documented attempt to make a referral by the outreach worker to a medical case management agency, medical provider, residential substance abuse program and/or other core service provider, of the client's choice;
- documentation of follow-up on referrals to ensure that the client is enrolled in medical care and treatment;
- final disposition of the client must be documented in SDIS, the client's chart or service log indicating whether or not the client was connected to care (i.e., referral was made; client was taken to a medical provider, medical case manager, or other core service provider; etc.) or if the case was closed with a statement as to why it was closed.

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 a High School diploma or GED. All staff providing outreach services must be certified through the State of Florida's Department of Health HIV/AIDS 104 course. Outreach workers must also receive training related to Limited English Proficiency (LEP). Outreach workers must attend periodic training provided by the Ryan White Program's Quality Management and Training Program provided by Behavioral Science Research (BSR).

Outreach providers must ensure that outreach workers are knowledgeable about resources and providers of medical care, substance abuse treatment, medical case management, and other core and support services. At a minimum, the outreach provider should have reference material on hand which provides information on services offered, intake requirements, hours of operation, and contact personnel information. Outreach workers must also have on hand 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 up to 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.
3. **Cultural Sensitivity.** Providers are encouraged to be creative in developing outreach programs that are culturally sensitive and that meet the specific needs of the identified target sub-populations (i.e., substance abusers, illiterate persons, hard of hearing, sex workers, etc.). It is desirable that outreach workers reflect the community in which they are working.
4. **Documentation of Units of Service.** Providers are required to document in the client's chart each unit (15-minute encounter) of outreach service performed (including the time spent) as a face-to-face encounter, telephone contact, collateral encounter on behalf of the client, coordination of care, travel, or referral activity on behalf of a client.

Outreach workers may also record and bill for time spent attending authorized Ryan White Program trainings (TRN), such as monthly case management and case management supervisor trainings, outreach worker trainings, Service Delivery Information System trainings, and quarterly Ryan White Program Provider Forums. (NOTE: The TRN code may not be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code cannot be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, or other employer-required training.) Travel time is not included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code.

5. **Connection to Care.** Providers are expected to demonstrate through documentation on file at the provider agency that at least twenty-five (25) percent of people contacted and billed for are actually brought into or returned to medical care and/or other core services or that a case was closed, on a quarterly basis. Connections to care will also be monitored by the County on a quarterly basis through the Service Delivery Information System (SDIS) and/or analysis of outreach data conducted by Behavioral Science Research Corporation, as a Quality Management Program activity.

- B. Rules for Reimbursement:** Providers will be reimbursed on the basis of a line-item budget for Part A and MAI-funded outreach services. Ryan White Program outreach services will be paid on the basis of full-time equivalent (FTE) employees at a salary to be negotiated between the service provider and the County, as well as on the basis of other direct and administrative costs. Reimbursement of salaries will be based on the approved budget and productivity as recorded by hours spent doing outreach activities, people contacted, their risk factors, and the number of people connected to care. All administrative and/or indirect expenses allocated to this service category (other than those associated with the delivery of outreach services to clients) are capped at 10% of the total budget.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of an outreach contact.

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

FOOD SERVICES
(Year 20 Service Priorities #10 and #12)

Food services include **Food Bank** and **Home-Delivered Meals**. Providers must offer nutritional counseling to all food service clients through qualified staff supervised by a licensed dietitian or nutritionist. Clients may not be enrolled in more than one Ryan White Part A-funded food service program simultaneously, except if the client needs to access food bank services only for the purpose of obtaining personal hygiene products while enrolled in the home-delivered meals program.

I. Food Bank (Priority #10)

This program is a central distribution center providing groceries, including personal hygiene products when available, for indigent HIV+ clients. The food is distributed in cartons or bags of assorted products to eligible Ryan White Program clients.

A. Program Operation Requirements:

Standard Provisions

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

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

The provision of this service will be limited to twelve (12) occurrences within the Ryan White Part A Fiscal Year (March 1, 2010 through February 28, 2011). 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 three (3) months, or one week per month for 12 months, in the Fiscal Year or any variation thereof, with the absolute limit of 12 occurrences in a Fiscal Year.

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

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

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

Additional Occurrences

A **severe** change to the person's medical condition (i.e., new HIV-related diagnosis/symptom, wasting syndrome, protein imbalance, recent chemotherapy, etc.) may warrant additional occurrences of food bank services. However, additional occurrences require certification in the form of a completed **Ryan White Program Nutritional Assessment Letter for Food Bank Services**. This Letter of Nutritional Assessment must be completed by an independent physician or registered dietitian not associated with the Part A-funded food bank provider. The client must be reassessed for the "warranting" medical condition every three (3) months. The physician or registered dietitian must specify the frequency and number of additional food bank visits (occurrences) that should be allowed for the client (maximum of twelve).

Provision for Families

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

Providers must demonstrate their capacity to provide ethnic foods and foods suited to special client dietary needs.

- B. Rules for Reimbursement:** Providers will be reimbursed based on properly documented invoices reflecting the distribution of weekly bags of groceries, including personal hygiene products, plus a dispensing charge to be agreed upon between the provider and the Office of Grants Coordination. The cost of the weekly bag of groceries will not exceed \$50.00. Providers will also submit a quarterly reconciliation of actual expenditures for food costs, staffing expenses, and other line items as listed on the approved budget.
- C. Additional Rules for Reporting:** Providers must report monthly activities according to client visits (i.e., weekly occurrences).
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation) is required for this service. Referrals expire on February 28th of each Fiscal 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 “warranting” medical condition every three (3) months. Providers must document that HIV+ clients who receive Ryan White Part A-funded food bank services have a gross household income that does not exceed 250% of the 2010 Federal Poverty Level (FPL).

Clients receiving food bank services must be documented as having been properly screened for Food Stamps, Medicaid Waiver, or other public sector funding as appropriate. Medical case managers must document a client’s need for food services in the client’s Plan of Care (POC), and indicate if the client is eligible to access food services under other various available programs, with the understanding that the Ryan White Program-funded food bank services are provided on an emergency basis. If the client is eligible to receive food service benefits from another source, the medical case manager will assist the client in applying to such program(s). If the client already receives food stamp benefits at the time he/she applies for Ryan White Program-funded food bank services, the client must submit a copy of his/her Food Stamp program award/benefit letter as documentation that the award is \$25.00 or less per month in food stamp benefits. If the client applied for Food Stamp benefits and was denied, a copy of the denial letter must be filed in the client’s chart and a copy should accompany the referral for food bank services.

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

In addition, referrals for food bank services must clearly state that the client is not currently receiving Part A-funded home delivered meals.

II. Home-Delivered Meals (Priority #12)

This service provides nutritionally balanced home-delivered meals for persons living with AIDS, or under certain circumstances persons who are HIV+ , are indigent, disabled, and homebound, as defined by Medicaid Project AIDS Care (PAC Waiver) and as certified by a physician. PAC Waiver defines a homebound individual as one who is "confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals." In addition, clients accessing this service must be functionally impaired. A functional impairment means difficulty performing one or more activities of daily living (i.e., bathing, dressing, walking, eating), and are not capable of preparing meals. Additionally, it must be documented that no other person in the client's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation. **A physician's certification of a client's homebound status is required and must be updated every three (3) months. This certification must be kept on-site in the client chart at the home-delivered meal provider agency.**

- A. Program Operation Requirements:** This service includes the provision of both frozen and hot meals. Providers must demonstrate their capacity to provide ethnic foods and food suited to special client dietary needs. A meal must be defined according to current American Dietary Association (ADA) guidelines (minimum daily requirements).
- B. Rules for Reimbursement:** Providers will be reimbursed on the basis of a delivered meal that meets commonly accepted nutritional guidelines, at a rate not to exceed \$6.25 per meal (frozen or hot) with a maximum of three (3) meals per day per client. The projected cost per meal must include the cost of nutritional counseling.

- C. Additional Rules for Reporting:** Providers must report monthly activity on the basis of a delivered meal meeting the nutritional guidelines indicated above under program operations requirements.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service. Every three (3) months, client eligibility for this service must be re-certified by a medical case manager and the physician's certification of homebound status must be re-confirmed and updated. Providers must document that persons receiving Part A-funded home-delivered meal services: (1) are homebound as defined by Medicaid Project AIDS Care (PAC) Waiver and as certified by a physician. (PAC Waiver defines a homebound individual as one who is "confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals."); (2) clients accessing this service must be functionally impaired. A functional impairment means difficulty performing one or more activities of daily living (i.e., bathing, dressing, walking, eating), and are not capable of preparing meals. Additionally, it must be documented that no other person in the client's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation; (3) are current permanent residents of Miami-Dade County; (4) have AIDS (as defined by the CDC) or are HIV+ with a condition (certified by a physician) that makes home-delivered meals necessary; and (5) have a gross household income that does not exceed 300% of the 2010 Federal Poverty Level. While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Part A-funded home delivered meals.

PLEASE NOTE: A complete referral for this service includes either the Ryan White Program Certified Referral or an Out-of-Network Referral (including appropriate supporting documentation) AND the physician's certification of homebound status. No referral for home-delivered meals may be for longer than three (3) months duration and all supporting documentation must be kept in the client chart on-site at the home-delivered meal provider agency.

Clients receiving home-delivered meals must be documented as having been properly screened for other public sector funding as appropriate. While clients qualify for and can access Medicaid Waiver, or other public or faith-based funding for home delivered meals, they will not be eligible for Ryan White Part A-funded home-delivered meals. In addition, referrals for home-delivered meals must clearly state that the client is not

currently receiving Part A-funded food bank services, except for personal hygiene products.

ALSO NOTE: Where the HIV positive status of the client and a medical condition renders the client homebound, physicians must indicate whether the condition is temporary or permanent, and if temporary, the period of time that home-delivered meal service is authorized. If no such time indication is provided, such certification will last for a maximum of thirty (30) days.

PSYCHOSOCIAL SUPPORT SERVICES
(Year 20 Service Priority #11)

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

Clients must have a medical case management referral to receive this service. 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 assignments to subsequent therapy/counseling levels 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.

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, psychology, or a related field 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 socioemotional 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 client's psychosocial mental health and promote feelings of well-being. Services will include crisis counseling, periodic re-assessments, and re-evaluations of plans and goals documenting progress. 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 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.

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 this service and must be updated every six (6) months. Clients receiving Ryan White Program Part A-funded psychosocial support services must be documented as having a gross household income below 300% of the 2010 Federal Poverty Level (FPL).

TRANSPORTATION VOUCHERS
(Year 20 Service Priority #13)

This service provides specially-designated, discounted Miami-Dade Transit Agency (MDTA) Metro (transportation) EASY Tickets to eligible HIV+ clients attending medical and/or social service appointments. The client's qualified dependents and caregivers are also eligible to receive reduced rate tickets if attending medical and/or social service appointments along with the client. This includes monthly tickets.

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

- A. Program Operation Requirements:** EASY Tickets cost \$50.00 (fifty dollars) per month for unlimited trips during the calendar month. These specially-designated EASY Tickets will not be usable in other months and are not "re-loadable." The amount for EASY Tickets should be consistent throughout the duration of the contract period and must take into consideration the total budget request, agency capacity, client eligibility, and demand for this service. For any given month, once an allotment of tickets has been exhausted, providers may not distribute additional tickets for that month.

Monthly transportation tickets must be distributed in a timely manner (no later than the 5th day of the month) in order to maximize ticket usage. Unused transportation tickets should be returned to the MDTA for credit. Agencies must follow MDTA's procedures for ticket returns.

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

Providers must specify criteria, policies, and procedures utilized to determine transportation EASY Tickets allotments for clients that must take into account not only minimum requirements, but also consideration for those clients who demonstrate the greatest need for these services.

Documentation of multiple monthly medical and social service appointments must be submitted by the client to his/her medical case manager before the client can receive transportation assistance. If allowable appointments are appropriately documented in the client chart, the Ryan White Program will not restrict the number of months in which the client can receive transportation services during the Fiscal Year.

- B. Rules for Reimbursement:** Providers will be reimbursed based on properly documented service utilization reports from the Service Delivery Information System (SDIS), indicating the date of EASY Ticket distribution, client CIS number, and dollar amount including dispensing charge. Dispensing charges, not to exceed 15%, will be reimbursed after services have been provided, client utilization and disbursement information is submitted to the County, and vendor payment has been documented. This service is subject to audit by the Office of Grants Coordination. EASY Ticket orders, invoices, and payments, as well as monthly distribution logs signed by the client, will be reviewed.
- C. Additional Rules for Reporting:** Providers must report monthly activity according to the dollar amount of the tickets issued, the number of tickets, and the unduplicated number of clients served.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated every six (6) months. Clients receiving Ryan White Program Part A-funded transportation assistance must be documented as having a gross household income below 150% of the 2010 Federal Poverty Level (FPL). Clients receiving transportation EASY Tickets must be documented as having been properly screened for other public sector funding as appropriate every six (6) months. Qualified dependents and caregivers are eligible to receive transportation tickets as long as they are not eligible to receive and cannot access this service under another funding source [i.e., Miami-Dade County Golden Pass Program, Special Transportation Services (STS), Medicaid, etc.]. While clients qualify for and can access other public funding for transportation services, they will not be eligible for Ryan White Part A-funded transportation EASY Tickets.

LEGAL ASSISTANCE
(Year 20 Service Priority #14)

This service provides **Legal Assistance** to individuals living with HIV or AIDS who would not otherwise have access to these services with the goal of maintaining clients in health care. Services include assistance with access to benefits and health care-related services.

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

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

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

- B. Rules for Reimbursement:** The unit of reimbursement for this service is *one hour* of legal consultation and/or advocacy provided by an attorney or paralegal at a rate not to exceed \$90.00 per hour.
- C. Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of *one hour of legal consultation and/or advocacy* provided by an attorney or paralegal.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated annually. Providers must also document that HIV+ clients receiving Ryan White Program Part A-funded legal assistance are permanent residents of Miami-Dade County and have a gross household income that does not exceed 200% of the 2010 Federal Poverty Level.

TRANSPORTATION SERVICES (VANS)
(Year 20 Service Priority #15)

This program provides free transportation to and from HIV service programs, Miami-Dade HIV/AIDS Partnership functions, and/or home for HIV+ clients and their qualified dependents and/or caregivers in cars or vans operated directly by service providers. **Funding for this service is restricted to providers located in the area of South Miami-Dade County (designated as South of SW 88th Street, Kendall Drive).**

Providers of **Transportation Services (Agency Based Transportation/Vans)** must demonstrate coordination with Miami-Dade transportation agencies and services, Medicaid Special Transportation and Special Transportation Services (STS) and other existing transportation programs to avoid duplication of services.

- A. Program Operation Requirements:** These services are provided in combination with core services (outpatient medical care, oral health care, pharmaceuticals, mental health therapy/counseling, substance abuse treatment/counseling, and/or medical case management services) to clients enrolled in HIV service programs.
- B. Rules for Reimbursement:** The unit of service for reimbursement for this service will be a one-way trip at a rate not to exceed \$13.00 per one-way trip (i.e., each way).
- C. Additional Rules for Reporting:** Monthly activity reporting for this service will be on the basis of one-way trips.
- D. Special Client Eligibility Criteria:** A Ryan White Program Certified Referral or an Out-of-Network Referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated every six (6) months. Providers must document that eligible HIV+ clients who receive Ryan White Program Part A-funded agency based transportation services also: (1) have a gross household income that does not exceed 150% of the 2010 Federal Poverty Level; and (2) have been documented as having been properly screened for other public sector funding as appropriate. Qualified dependents and/or caregivers are eligible to receive free agency-based transportation if riding along with the client. While clients qualify for and can access other public funding for transportation services, they will not be eligible for Ryan White Program Part A funding for this service.

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