SERVICE DESCRIPTIONS FOR RYAN WHITE PART B and STATE SERVICES FUNDING

Applicable HSDA:
Galveston

Appendix A: Galveston HSDA
Ryan White Part B
Service Category Descriptions

Local Service Category:	**Emergency Financial Assistance**
Amount Available	**$40,415**
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition:	Support for Emergency Financial Assistance (EFA) for essential services including utilities, housing, food (including groceries and food vouchers), or prescriptions provided to PLWHs with limited frequency and for a limited period of time. The intent of these funds is to support a PLWH for a short duration. An emergency is defined as a sudden, urgent, and unexpected occurrence or occasion requiring immediate action.
Local Service Category Definition:	Ryan White/State Services funds may be used to provide services in the following categories: 1. ADAP eligibility determination period 2. Dispensing fee for ADAP medications 3. Emergency Financial Assistance EFA can be used during the ADAP eligibility determination period. Initial medications purchased for this use is not subject to the $800/person/year cap. EFA can be used to reimburse dispensing fees associated with purchased medications. Dispensing fees are not subject to the $800/person/year cap. EFA is an allowable support service with an $800/year/person cap. • The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. • Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all PLWHs. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Emergency Financial Assistance funding for these purposes will be the payer-of-last-resort, and for limited amounts, limited use and limited periods of time. Emergency Financial Assistance provides funding through: • Short-term payments to agencies • Establishment of voucher programs Emergency Financial Assistance to individual PLWHs is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Financial hardship must be documented each time funds are used. Assistance is provided only for the following essential services/subcategories: • Utilities such as household utilities including gas, electricity,

	propane, water, and all required fees • Housing such as rent, mortgage payment, or temporary shelter. EFA can only be used if HOPWA assistance isn't available • Food such as groceries and food vouchers • Prescription assistance such as short-term, one-time assistance for any medication and associated dispensing fees as a result or component of a primary medical visit (30-day supply) and • The cost of corrective prescription eye wear
Unit Definition:	Prescription = per prescription
	Utilities = per transaction
	Food = per visit
Services to be Provided:	The agency must adhere to the following guidelines in providing these services: • Assistance must be paid to the vendors, merchants, landlords, etc. through short-term payments to agencies or the establishment of voucher programs. No payments may be made directly to individual PLWHs or family members. • Documentation of the nature of the emergency need is required. Failure to appropriately document emergency need may result is disallowed costs. • Documentation that PLWH was unable to access Housing Opportunities for People With AIDS (HOPWA) Short Term Rental Mortgage Utilities (STRMU) funds prior to utilizing these funds. • Documented plan to increase PLWH self-sufficiency and prevent need for financial assistance in the future.
Eligibility for Service:	Person living with HIV, resident of HSDA; 300% below poverty guidelines.
Agency Requirements:	The agency must comply with **the DSHS Emergency Financial Assistance Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all PLWHs. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Emergency Financial Assistance funding for these purposes will be the payer-of-last-resort, and for limited amounts, limited use and limited periods of time. Agency must work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. Agency must ensure that Ryan White funds are the payer of last resort.

	Agency will comply with TRG's Wait List Policy (SG-1719).
Funding Restrictions:	Agency may only expend funds on essential subcategories listed on their approved budget. Direct cash payments to PLWHs are not permitted. No funds may be used for any expenses associated with the ownership or maintenance of a privately owned motor vehicle.
Staff Requirements:	NA
Special Requirements:	NA

Local Service Category:	**Local AIDS Pharmaceutical Assistance Program**
Amount Available**:**	**$20,000**
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Costs
DSHS Service Category Definition:	**Local Pharmaceutical Assistance Program** The purpose of a Local AIDS Pharmaceutical Assistance Program (LPAP) is to provide therapeutics to treat HIV or to prevent the serious deterioration of health arising from HIV in eligible individuals, including measures for prevention and treatment of opportunistic infections. An LPAP is a program to ensure that PLWHs receive medications when other means to procure medications are unavailable or insufficient. As such, LPAPs are meant to serve as an ongoing means of providing medications for a period of time.
Local Service Category Definition:	**Local Pharmaceutical Assistance Program** Local Pharmaceutical Assistance Program is defined as reimbursement for prescriptive and/or non-prescriptive medications covered under the Part B Local Drug formulary and not including drugs available free of charge. ADAP dispensing fees are covered under this service. *Prescription co-payments and deductibles are **not** covered under this service.*
Unit Definition:	Per prescription
Services to be Provided:	
Eligibility for Service:	Person living with HIV; resident of HSDA; 400-500% of federal poverty guidelines. Prescription medication not covered under the Texas Medicaid program, State ADAP, or any other third party payer.
Agency Requirements:	The agency must comply with **Local Pharmaceutical Assistance (LPAP) Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Medications must be on the approved LPAP Formulary to be eligible for reimbursement. Agency will comply with TRG's Wait List Policy (SG-19). Agency must either directly, or via subcontract with an eligible 340B Pharmacy program entity (to the extent possible), provide the following: • PLWHs will not be put on wait lists nor will AIDS Pharmaceutical Assistance services be postponed or denied due to funding. • A comprehensive financial intake application to determine eligibility for this program to insure that these funds are used as a last resort for purchase of medications. • Documented capability of interfacing with the Texas State AIDS Drug Assistance Program operated by the Texas Department of State Health Services. This capability must be fully documented in the proposal. • Ensure, where possible, participation in Pharmaceutical Care Patient drug assistance program. • Develop system to cover the cost of the Texas HIV

	Medication Program medication dispensing fee per prescription.
Staff Requirements:	Pharmacy staff must be appropriately licensed to dispense medication in the State of Texas.
Special Requirements:	**NA**

Local Service Category:	**Medical Transportation**
Amount Available:	**$25,000**
Budget Requirements or Restrictions:	**Maximum of 10% of budget for Administrative Cost.**
DSHS Service Category Definition:	Services include transportation to public and private outpatient medical care and physician services, case management, substance abuse and mental health services, pharmacies, and other services where eligible PLWHs receive Ryan White/State Services-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. Services may be provided through: • Contracts with providers of transportation services • Voucher or token system • System of mileage reimbursement that does not exceed the federal per-mile reimbursement rates • System of volunteer drivers, where insurance and other liability issues are addressed • Purchase or lease of organizational vehicles for PLWH transportation, with prior approval from HRSA/HAB for the purchase.
Local Service Category Definition:	**A. General Transportation:** The provision of essential medical transportation services through the use of employee drivers and agency operated vans or automobiles to eligible individuals residing in the defined HIV Service Delivery Area (HSDA). Essential medical transportation is defined as transportation to core medical services. **B. Vouchering Program:** Transportation vouchers to support the participation in core medical services are allowable under this service category. Vouchering programs may consist of gas vouchers and/or bus passes. Applicant must propose a standard voucher amount for each type of voucher to be distributed. The amount should be adequate to support the participation in core medical services.
Unit Definition:	**A. General Transportation:** Per one way trip **B. Vouchering Program:** Per voucher
Services to be Provided:	The intent of this funding is to provide essential transportation services to access core medical services for eligible individuals. **a. General Transportation:** Agency will develop and implement a general transportation program that provides essential transportation services through the use of employee drivers and agency operated vans or automobiles to eligible individuals. Transportation will include round trips to single and multiple destinations. Caregiver must be allowed to accompany the PLWH if necessary for minors and severely disabled. Essential transportation is defined as transportation to core medical services. **b. Vouchering Program** Transportation Voucher service is defined as providing vouchers for the

	essential transportation of eligible PLWHs. Vouchers consist of gas vouchers and bus passes. Provision of vouchers must be supported by documented core medical service appointments.
Eligibility for Service:	Person living with HIV, resident of HSDA; 400% below poverty guidelines.
Agency Requirements:	The agency must comply with **the DSHS Medical Transportation Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Agency will comply with TRG's Wait List Policy (SG-19). A. **General Transportation:** 3 or more consumers must be present in the vehicle to constitute a trip. A transportation form indicating that a core medical service appointment was attended is needed for documentation. Agency must establish and maintain a system for coordinating appointments for PLWH to maximize the utilization of general transportation resources. All equipment must be in compliance with State laws when transporting children. Agency must provide adequate adult supervision other than the driver when transporting children. The parent or legal guardian can determine who is authorized to ride with the child. This must be documented in writing prior to the transportation being provided. Agency must assure eligible PLWHs utilize Medicaid transportation service to the maximum extent possible. This is subject to audit by TRG and vendor may be required to reimburse TRG for transportation services billed to TRG for PLWHs who were eligible for Medicaid-supported transportation at the time of the service. Agency is responsible for maintaining documentation to evidence that drivers providing services have a valid Texas Drivers License and have completed a State approved "Safe Driving" course. Agency must maintain documentation of the automobile liability insurance of each vehicle utilized by the program as required by state law. All vehicles must have a current Texas State Inspection. Agency must maintain detailed records of mileage driven and names of individuals provided with transportation, as well as origin and destination of trips. Agency must ensure that medical transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and coverage must occur for Saturday medical appointments. Services shall include round trips to single and multiple destinations. Changes in hours of operation must be accompanied by advanced notice to PLWHs. **A. Vouchering Program:** If vouchers are available at hours different than the general transportation, hours must be posted in the lobby/waiting room and PLWH must be informed of those hours in writing Changes in hours of operation must be accompanied by advanced notice to PLWHs. Agency must have a system for tracking the purchase and distribution of

	vouchers. Documentation of core medical service appointments must be present within the primary service record.
Funding Restrictions:	Agency may only expend funds on essential subcategories listed on their approved budget. Purchase or lease of organizational vehicles for transportation requires prior approval from HRSA/HAB. Reimbursement methods may not involve cash payments to PLWHs. Mileage reimbursement rates will not exceed the federal reimbursement rate. Medical transportation cannot be used to transport a PLWH in need of emergency medical care
Staff Requirements:	All drivers must have a valid Texas Driver's License. The contractor must ensure that each driver has or is covered by automobile liability insurance for the vehicle operated as required by the State of Texas and that all vehicles have a current Texas State Registration. A picture identification of each driver must be posted in the vehicle utilized to transport PLWHs. Criminal background checks must be performed annually on all direct service transportation personnel prior to transporting any PLWHs. Drivers who have received traffic violations (speeding ticket, reckless driving, and/or DWI) within the past two years are not qualified to provide transportation services funded by TRG.
Special Requirements:	Agency must ensure that Ryan White funds are the payer of last resort. Individuals who qualify for transportation services through Medicaid are not eligible for these transportation services until Medicaid resources have been exhausted. ***Must comply with the applicable standards of care.***

Local Service Category	**Mental Health Services/Outpatient Psychiatric Services**
Amount Available**:**	**$68,900**
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition:	Mental health counseling services includes outpatient mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for affected family members or significant others.
Local Service Category Definition:	The provision of psychological and psychiatric treatment and counseling services, including individual and group counseling provided by a mental health professional licensed or authorized within the state, psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.
Unit Definition:	**Mental Health Services:** Per session **Psychiatric Services:** Per evaluation or follow-up
Services to be Provided:	**Mental Health Services:** • **Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible PLWH. • **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise PLWH, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for PLWH. A minimum of three (3) PLWHs must attend a group session in order for the group session to eligible for reimbursement. • Agencies are encouraged to have available to PLWHs all modes of services, i.e., crisis, individual, family and group. **Outpatient Psychiatric Services:** The program must provide, either directly or through referral: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis,

	acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.
Eligibility for Service:	For individual therapy sessions: person living with HIV; resident of HSDA; 500% below poverty guidelines. PLWH must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan.
Agency Requirements:	The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort. Agency will comply with TRG's Wait List Policy (SG-19). **Mental Health Services:** Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract with the TRG. Potential PLWHs who are Medicaid/Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible PLWHs may not be referred elsewhere in order that non-Medicaid/Medicare eligible PLWHs may be added to this grant). Failure to serve Medicaid/Medicare eligible PLWHs based on their reimbursement status will be grounds for the immediate termination of the provider's contract with the TRG. **Outpatient Psychiatric Services:** Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psychopharmacotherapy.
Staff Requirements:	**Mental Health Services:** Mental Health providers must have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LMSW, LPC or LMFT). Provider must submit documentation of the staff credentials, licensures and certifications.

	Outpatient Psychiatric Services: Director of the Program must be a Board-Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Provider must submit documentation of the Director's credentials, licensures and certifications and documentation of the Allied Health professional licensures and certifications.
Special Requirements:	**Inpatient Services are to be excluded, and are not allowable services provided under Ryan White funding.** All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. **Mental Health Services:** Under no circumstances will TRG reimburse more than two (2) units of individual therapy per PLWH in any single 24-hour period. **Outpatient Psychiatric Services:** PLWH must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the PLWH is in crisis and cannot be provided immediate services from the other programs/providers. In this case, PLWHs may be provided services, as long as the PLWH applies for the other programs/providers, until the other programs/ providers can take over services.

Local Service Category	**Oral Health Care**
Amount Available	**$100,000**
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Costs
DSHS Service Category Definition:	Support for Oral Health Services including diagnostic, preventive, and therapeutic dental care that is in compliance with dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals. Services will include routine dental examinations, prophylaxis, x-rays, fillings, and basic oral surgery (simple extractions), endodontistry and prosthodontics. Referral for specialized care should be completed if clinically indicated. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a PLWH's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room.
Local Service Category Definition:	The provision of restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Prosthodontics services to PLWH including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.
Unit Definition:	Per routine, prophylaxis, or specialty treatment.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, standard preventative procedures; oral prophylaxis; restorative care; oral surgery; root canal therapy; and fixed and removable prosthodontics.
Eligibility for Service:	Person living with HIV; resident of HSDA; 300% below poverty guidelines.
Financial Restrictions:	Cosmetic dentistry for cosmetic purposes only is prohibited. Therefore, all cosmetic dentistry must have prior approval from Administrative Agency (TRG). PLWHs may only receive $3,000 of service per year unless approved in writing by TRG.
Agency Requirements:	The agency must comply with **the DSHS Oral Health Care Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

	Dental facility and appropriate dental staff must maintain Texas licensure/certification and follow all applicable OSHA requirements for patient management and laboratory protocol. A comprehensive financial intake application to determine eligibility for this program to ensure that these funds are used as a last resort for purchase of medications. Documented capability of interfacing with the Texas State AIDS Drug Assistance Program operated by the Texas Department of State Health Services. This capability must be fully documented in the proposal. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort. **To ensure that Ryan White is payer of last resort, Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible PLWHs in the applicable counties of the HSDA**. Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible patients remain current throughout the contract term. Agency will comply with TRG's Wait List Policy (SG-19).
Staff Requirements:	State dental license.
Special Requirements:	NA

Local Service Category:	**A. Outpatient Ambulatory Medical Care** **B. Medical Case Management** **C. Non-Medical Case Management**
Amount Available**:**	**A. $185, 000** **B. $165, 000** **C. $70,000**
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Costs
DSHS Service Category Definition:	**A. Outpatient Ambulatory Medical Care (OAMC)** 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 (includes all medical subspecialties including ophthalmic and optometric services). As part of Outpatient and Ambulatory Medical Care, provision of laboratory tests integral to the treatment of HIV and related complications is included. Care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Early Intervention Services provided by Ryan White Part C and Part D programs should be included under Outpatient/Ambulatory Medical Care. Diagnostic Laboratory Testing includes all indicated medical diagnostic testing including all tests considered integral to treatment of HIV and related complications (e.g. Viral Load, CD4 counts, and genotype assays). Funded tests must meet the following conditions: • Tests must be consistent with medical and laboratory standards as established by scientific evidence and supported by professional panels, associations or organizations; • Tests must be (1) approved by the FDA, when required under the FDA Medical Devices Act and/or (2) performed in an approval Clinical Laboratory Improvement Amendments of 1988 (CLIA) certified laboratory or State exempt laboratory; and • Tests must be (1) ordered by a registered, certified or licensed medical provider and (2) necessary and appropriate based on established clinical practice standards and professional clinical judgment **B. Medical Case Management** Medical Case Management (MCM) is a proactive case management category intended to serve persons living with HIV with multiple complex health-related needs that focuses on maintaining PLWH in systems of primary medical care to improve related health outcomes.

	MCM is designed to serve individuals who have complex medical needs and may require a more intensive time investment, and who agree to this level of case management service provision. MCM Care Coordinators act as part of a multidisciplinary medical care team, with a specific role of assisting PLWHs in following their medical treatment plan and assisting in the coordination and follow-up of the PLWH's medical care between multiple providers (if necessary). The MCM Care Coordinator could be one of many access points to medical care and should not serve as a gatekeeper. The goals of this service are 1) the development of knowledge and skills that allow PLWHs to adhere to the medical treatment plan without the support and assistance of the MCM Care Coordinator and 2) to address needs for concrete services such as health care, public benefits and assistance, housing, and nutrition, as well as develop the relationship necessary to assist the PLWH in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system. Core components of MCM services are: 1) Coordination of Medical Care – scheduling appointments for various treatments and referrals including labs, screenings, medical specialist appointments, mental health, oral health care, and substance abuse treatment 2) Follow-up of Medical Treatments – includes either accompanying PLWH to medical appointments, calling, emailing, texting or writing letters to PLWHs with respect to various treatments to ensure appointments were kept or rescheduled as needed. Additionally, follow-up also includes ensuring PLWHs have appropriate documentation, transportation, and understanding of procedures. MCM staff must also encourage and enable open dialogue with medical healthcare professionals. 3) Treatment Adherence – the provision of counseling or special programs to ensure readiness for, and adherence to, complex treatments. **C. Non-Medical Case Management (NMCM)** **Non-Medical Case Management** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. NMCM provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas

	DSHS HIV Care Services Group Ryan White Part B program. Limitation: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.
Local Service Category Definition:	**A. Outpatient Ambulatory Medical Care (OAMC):** OAMC is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient, community-based, and/or office-based setting. This includes 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, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. **B. Medical Case Management:** Medical Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the PLWH's health and service needs. Medical Case Management can only be provided to those who are currently in or seeking to immediately start outpatient ambulatory medical care. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. Medical Case Management is seen as a professional level encounter that involves rigorous assessment and care planning to include skills and knowledge building with the goal of independence for the PLWH. Medical Case Management activities should promote the PLWH's improved clinical outcome. Key activities include initial comprehensive assessment of the PLWH's needs and personal support systems; assessment of acuity, development of an individualized care plan; coordination of the services required to implement the plan; monitoring to assess the efficacy of the plan; periodic re-evaluation and revision of the plan as necessary over the life of the PLWH: and tracking and reporting clinical outcomes. **C. Non-Medical Case Management** The purpose of Non-Medical Case Management is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. NMCM is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. NMCM is a working agreement between a PLWH and a NMCM Care Coordinator for an indeterminate period, based on PLWH need, during which information, referrals and NMCM is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. NCMC is both office-based and field based. NMCM Care Coordinators are expected to coordinate activities with referral sources where newly

	diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. NMCM also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). NMCM must document efforts to re-engage PLWH who have disengaged from care prior to closing them. NMCM extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services. Key activities include, but are not limited to, initial assessment of service needs, development of a comprehensive, individualized care plan, continuous monitoring to assess the efficacy of the care plan, re-evaluation of the care plan at least every six (6) months with adaptations as necessary, and ongoing assessment of the PLWH's and other key family members' needs and personal support systems
Unit Definition:	**A. Outpatient Ambulatory Medical Care:** Per visit or test **B. Medical Case Management:** Per 15 minutes of allowable service **C. Non-Medical Case Management:** Per 15 minutes of allowable service
Services to be Provided:	**A. Outpatient Ambulatory Medical Care (OAMC):** **OAMC Office/Clinic Visit** is defined as PLWH examination by a qualified Medical Doctor, Nurse Practitioner, and/or Physician's Assistant and includes all ancillary services below: • Eligibility Screening (as necessary) • Patient Medication/Treatment Education • Medication Access/Linkage • Ob/Gyn specialty procedures (as clinically indicated) • Radiology (as clinically indicated) • Nutritional Counseling (as clinically indicated) • Laboratory (as clinically indicated) • Radiology (as clinically indicated) **OAMC** services include on-site physician, physician extender, nursing, OB/GYN physician, OB/GYN services, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care and hospice referral, patient medication and adherence education, and patient care coordination. May include optometric or ophthalmic services and purchase of corrective prescription eyewear that is necessitated by HIV. The agency/clinic must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate agencies). • Continuity of care for all stages of disease progression; • Specialty Clinic Referrals. (i.e. obstetrics and gynecology, vision care, gastroenterology, neurology, etc.)

	• Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Prenatal and Perinatal Preventative education and treatment; • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); and • Access to HIV related research protocols (either directly or through established referral systems). Services provided by referral must be documented by memoranda of understanding or subcontracts. Copies of documentation of referral systems must be provided as part of this application. **B. Medical Case Management:** Medical Case Management is a clinically focused service and should be provided to PLWHs in a clinic as well as office setting. Medical case management is a working agreement between a PLWH and the medical case manager for a defined period of time based on the PLWH's assessed needs. The purpose of medical case management is to assist PLWHs with the procurement of needed services either through the agency or referral sources so that the problems associated with living with HIV are mitigated. Identifying and screening PLWHs including screening for third party payor and potential abuse; completing a comprehensive intake, assessing each PLWH's health history and current medical and service needs; assessing and documenting acuity; developing and regularly updating an individualized care plan based upon the PLWH's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of PLWHs to decrease service gaps and remove barriers to services helping PLWHs develop and utilize independent living skills and strategies; tracking health outcomes; and discharging PLWHs who have reached independence or not longer have identified needs. **C. Non-Medical Case Management** Non-Medical Case Management is a service based on need and is not appropriate or necessary for every PLWH. NMCM is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). NMCM should not be used as the only access point for medical care and other services. PLWH who do not need guidance and assistance in improving/gaining access to needed services should not be enrolled in NMCM services. When PLWH can maintain their care, they should be graduated. PLWH with ongoing existing needs due to impaired cognitive functioning, legal issues, or other documented concerns meet the criteria for NMCM services.

	Key activities include, but are not limited to, initial assessment of service needs, development of a comprehensive, individualized care plan, continuous monitoring to assess the efficacy of the care plan, re-evaluation of the care plan at least every six (6) months with adaptations as necessary, and ongoing assessment of the PLWH's and other key family members' needs and personal support systems In addition to providing the psychosocial services above, NMCM may also provide benefits counseling by assisting eligible PLWH in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).
Eligibility for Service:	**A. Outpatient Ambulatory Medical Care** Person living with HIV; resident of HSDA; 300% or below poverty guidelines. **B. Medical Case Management** Person living with HIV; resident of HSDA; 500% or below poverty actively in medical care. **C. Non-Medical Case Management** Person living with HIV; resident of HSDA; 500% or below poverty actively in medical care.
Agency Requirements:	The agency must comply with **the DSHS Outpatient Ambulatory Medical Care, Case Management, and Local AIDS Pharmaceutical Assistance (LPAP) Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Must comply with the applicable Standards of Care, Clinical Protocols and Best Practices Agency will comply with TRG's Wait List Policy (SG-19). **A. Outpatient Ambulatory Medical Care** Providers and agency must be Medicaid/Medicare certified. Agency must implement and maintain a billing system for Medicaid, Medicare, and appropriate insurance. Agency must implement and maintain a system for tracking program income per DSHS Contractor's Financial Procedure Manual section 8.01. **B. Medical Case Management** Agency must have qualified staff assigned to supervise medical case managers. **C. Non-Medical Case Management** Agency must have qualified staff assigned to supervise medical case managers.

Staff Requirements:	**A. Outpatient Ambulatory Medical Care (OAMC):** Agency is responsible for ensuring that services are provided by State licensed physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, x-ray technologists, State licensed dieticians, social workers and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease**.** **B. Medical Case Management** Preferred qualifications for a medical case manager (MCM) are a degree in health, human or education services and one year of case management experience with PLWH and/or persons with a history of mental illness, homelessness, or chemical dependence. All MCMs and supervisory staff must pass online and on-site training requirements to maintain employment. **C. Non-Medical Case Management** Preferred qualifications for a NMCM Care Coordinators are a degree in health, human or education services and one year of case management experience with PLWH and/or persons with a history of mental illness, homelessness, or chemical dependence. All NMCM Care Coordinators and supervisory staff must pass online and on-site training requirements to maintain employment.
Special Requirements:	**Applicants must apply for OAHS, MCM, and NMCM funding.** **A. Outpatient Ambulatory Medical Care (OAMC):** **OAMC Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Services eligible for such reimbursement may not be billed to this contract. Under no circumstances may the Contractor bill TRG for the difference between the reimbursement from Medicaid, Medicare or Third party insurance and the fee schedule under the contract. Potential PLWHs who are Medicaid/Medicare eligible or have other Third party payors may not be denied services by the Agency based on their reimbursement status (Medicaid/Medicare eligible PLWHs may not be referred elsewhere in order that non-Medicaid/Medicare eligible PLWHs may be added to this contract). Failure to serve Medicaid/Medicare eligible PLWHs based on their reimbursement status will be grounds for the immediate termination of contract. All OAMC services must meet or exceed current Public Health Service guidelines for the treatment and management of HIV. **Inpatient Medical Care is to be excluded, and is not an allowable service provided under Ryan White funding.**

Appendix A: Galveston HSDA
DSHS State Services
Service Category Descriptions

Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
$116,866	**$116,875**
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost. *ADAP dispensing fees are not allowable under this service category.*
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help PLWH continue medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible PLWH to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Unit Definition:	Per payment of premium, deductible, co-insurance, and/or co-payment.
Services to be Provided:	Contractor may provide assistance with insurance premium payments, co-payments, co-insurance and/or deductibles. *ADAP dispensing fees are not allowable under this service category.*
Eligibility for Services:	Person living with HIV who has 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans); resident of HSDA. Local Financial Eligibility Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: PLWHs who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.
Agency Requirements:	The agency must comply with **the Eastern HASA Health Insurance Premiums & Cost Sharing Assistance (HIP) Policy and Procedure**. The agency must have policies and procedures in place that comply with the requirement ***prior*** to delivery of the service. Agency must also: • Provide a comprehensive financial intake/application to determine eligibility for this program to insure that these funds are used as a last resort in order for the PLWH to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • PLWHs will not be put on wait-lists nor will Health Insurance Premium

	and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency. • Conduct marketing in-services with area service providers to inform them of this program and how the PLWH referral and enrollment processes function. • Utilizes the approved prioritization of cost sharing assistance when limited funds warrant it (premiums take precedence). o **Priority Ranking of Requests (in descending order)**: ▪ HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) ▪ Non-HIV medication co-pays and deductibles ▪ Co-payments for provider visits (eg. physician visit and/or lab copayments) ▪ Medicare Part D (Rx) premiums ▪ APTC Tax Liability ▪ Out of Network out-of-pocket expenses
Staff Requirements:	NA
Special Requirements:	See DSHS HIV/STD Policy No. 260.002 ***Must comply with the applicable standards of care.***