University Health
Thinking beyond

Ryan White Program

University Health Ryan White Part A & MAI Programs

Standards of Care

The purpose of these Standards of Care are to ensure that all Eligbility & Servcices requirements for the Ryan White Program are met and that quality care and services are being provided to all persons living with HIV/AIDS in San Antonio Services Delivery Area.

Contents

Introduction

The Standards of Care (SoC) are the Eligibility and Service Standards requirements that Subrecipients (also referred to as Service Providers) are contractually obligated to meet when providing HIV/AIDS Core Medical and Supportive Health Services funded by University Health Ryan White Program.

Establishing the Standards of Care will ensure the Ryan White Program:

- Provide services that improve health outcomes for people living with HIV along the HIV Care Continuum, with the ultimate goal being viral suppression;
- Provide clients with high quality care through experienced, trained, and qualified staff
- Provide Consumer Responsibilities and Rights;
- Provide services that are client centered, trauma informed, and culturally and linguistically appropriate;
- Comprehensively inform clients of services, establish client eligibility and provide equitable access to services;
- Provide coordinated care and referrals to needed services;
- Provide services to historically underserved populations, including but not limited to women, children, youth, transgender and gender non-conforming individuals, and people of color; and
- Ensure clients apply and receive services that are free of discrimination based on race, color, sex, gender, ethnicity, national origin, religion, age, class, sexual orientation, housing status, and physical or mental ability.

The Standards of Care are designed for Services that are funded for Eligible clients by Ryan White Part A and MAI Programs in the following jurisdictions:

- Transitional Grant Area (TGA)
    - Include Health Resources and Services Administration (HRSA) funded grant programs
        - Ryan White Part A
        - Minority AIDS Initiative (MAI)
    - Comprises of the following counties for services:
        - Bexar
        - Comal
        - Guadalupe
        - Wilson

The Standards of Care are designed to monitor and enhance the quality of care provided in the service delivery areas by setting goal-specific measurable outcomes. Each service category Standard includes, as applicable:

- HRSA Service Category Description
- Program Guidance
- Services
- Limitations
- Statement of Need
- Standards Requirements & Monitoring Indicators
- References

It is important to note that the Standards of Care are a living document and will evolve based on:

- Ryan White Legislation Updates, Changes, and/or Modifications,
- HRSA Regulations Updates, Changes, and/or Modifications,
- HRSA Policy Updates, Changes, and/or Modifications,
- The changing needs and realities of the persons living with HIV (PLWH) within the service delivery areas,
- The capacity of the service delivery areas.

The University Health Ryan White Program Administration Staff, the San Antonio Area HIV Health Services Planning Council, and Planning Council Support Staff continually monitor, propose revisions, and update the Standards of Care as needed.

Comments regarding this document or considerations for future revisions should be directed in writing to the following University Health Ryan White Program Administration and/or San Antonio Area HIV Health Services Planning Council Staff.

Name	Title	Email
Leah Meraz, MPA	Senior Director Ryan White Program Administration	Leah.Meraz@uhs-sa.com
Tanya Khalfan Mendez, MPH, CHES	Director Program	Tanya.KhalfanMendez@uhs-sa.com
Annie Johnson	Director Operations	Annie.Johnson@uhs-sa.com
Mary Kay Mitchell, M.Jur.	Director Quality and Compliance	Mary.Mitchell@uhs-sa.com
Lisa Garces	Administrative Assistant Ryan White Program Administration	Lisa.Garces@uhs-sa.com

Consumer Responsibilities and Rights

Consumer Responsibilities

Respect, Courtesy, and Confidentiality

You have the responsibility to treat health and social service providers and staff with respect and courtesy at all times.

Giving Correct and Complete Information

You have the responsibility to give your provider accurate and complete information about your health condition and social situation, medication use, past and current treatment and the names and addresses of other providers you are using or have used. You must give this information to the best of your ability. You are responsible for coming to appointments with your providers, prepared to ask questions if needed and be able to tell them about things that concern you. This makes it easier for the providers to give you the best information about your care.

Seeking Facts About Your Care

You have the responsibility to ask questions about the care you are receiving if you do not completely understand it. This means that you should know about the risks, benefits and financial aspects of your care. You also have the right to have advocate/s ask about this information.

Following the Treatment Plan

You have the responsibility to follow treatment plans that you and your provider/s have agreed upon. You have the responsibility to tell your provider right away if you decide to stop treatment or go against your provider's advice. You are responsible for what happens to you.

Scheduled Appointments

You have the responsibility to keep appointments that you and your providers have scheduled. If you have to cancel, you are responsible for telling your provider that you will not be there.

Communicating Your Financial Needs

You have the responsibility to give accurate and complete information about third-party payers, (like insurance companies, Medicaid, Medicare, etc.) to your providers and their facilities. You should make sure that you give them any forms that they may ask for, or to send in any forms that are required of you as soon as you possibly can. You also have the responsibility to talk to your providers about your financial situation, regarding your financial needs and tell them of you need help in figuring out what your financial needs are before you start receiving services from your provider.

Rules and Regulations of Service Provider Organizations

You have the responsibility to follow the rules and regulations of your providers and their agencies/facilities.

Voicing Complaints and Grievances

You have the responsibility to voice complaints and present grievances in an appropriate and timely manner. You should do this by following the providers' grievance policies and procedures and you may ask for help in doing this if you need it.

Continuing Care

You have the responsibility to ask when and where to go for more treatment and follow-up services whenever you leave a providers' facility or care.

An Advanced Directive for Care

You have the responsibility to make formal decisions about your care that can be used if you are not able to speak for yourself if you become ill. These include living wills, health care proxies, and durable powers of attorney for health and social services.

Access to Financial Information

You have the responsibility to look and ask questions about all health care bills and to get referrals and help with any payment problems.

A Consumer Grievance Procedure

You have the responsibility to voice complaints, to suggest changes and to be informed about how to file a grievance (a formal written complaint) and to do this without harassment, interference and pressure.

Confidentiality and Access to Records

You have the responsibility to have all of your records kept strictly confidential and not to be released without your written permission. To access all of your records and to have copies of these at a fair copying cost.

Consumer Rights

Respect, Courtesy, And Privacy

You have the right to be treated at all times with respect and courtesy within a setting, this provides you with the highest degree of privacy possible.

Freedom From Discrimination

You have the right to freedom from discrimination because of age, ethnicity, gender, religion, sexual orientation, values and beliefs, marital status, medical condition, or any other arbitrary criteria.

Access to HIV/AIDS Service Information

You have the right to be informed by your healthcare and/or social service provider about the full range of available HIV/AIDS treatments and about related available social and support services. To be advised of the risks and to discuss benefits of any proposed treatments. You have the right to give your informed consent to any treatments or services before they are provided.

Identity and Provider Credentials

You have the right to know the names, titles, specialties, and affiliation of all health and social service providers and anyone else involved in your care and to know about the health or social service organization's policies and procedures.

Culturally Sensitive Sharing of Information

You have the right to have information shared with you in a respectful manner and in a way that is easy to understand, which takes into account the differences in each person's background, culture, and preferences.

Consent and the Care Plan

You have the right to be informed involved in and make individualized plane of care prior to the start of and during the course of treatment and to disagree, change your mind, or request a medical second opinion without affecting the ongoing availability of treatment services. The second opinion provider must notify you of any change they have made to your care plan before it happens.

Choice and Access to Service

You have the right to be informed of all available services upon intake and to choose and access all treatment/services for which you qualify.

Declining Service
You have the right to decline treatment/services without pressure from your health care or social service provider, to refuse to participate in any research studies or experiments that the provider may recommend, to change your mind after refusing or consenting to treatment, trial, counseling, or any other service without affecting ongoing care, and to make these decisions without pressure from your services.

Naming an Advocate
You have the right to choose an advocate (such as a family member of another person) to give you support and to represent your rights. This person (the advocate) makes sure that your rights are not forgotten due to your HIV status. They also make sure that you are getting the correct kind of HIV services and care.

An Advanced Directive for Care
You have the right to make formal decisions about your care that can be used if you are not able to speak for yourself if you become ill. These include living wills, health care proxies, and durable powers of attorney for health and social services.

Access to Financial Information
You have the right to look and ask questions about all health care bills and to get referrals and help with any payment problems.

A Consumer Grievance Procedure
You have the right to voice complaints, to suggest changes and to be informed about how to file a grievance (a formal written complaint) and to do this without harassment, interference and pressure.

Confidentiality and Access to Records
You have the right to have all of your records kept strictly confidential, not to be released without your written permission. And to access all of your records and to have copies of these at a fair copying cost.

Freedom from Constraints
You have the right to be free from all types of constraints when you deal with health or social service providers and treatment plans.

Transfers and Continuity of Care
You have the right to uninterrupted treatment. If possible, your requests to leave one provider and be seen by another should be honored and happen as soon as possible. You may NOT be transferred TO another provider or facility without an explanation for the transfer. You must be informed of other options that are available.

Eligibility Standards

Ryan White Part A Eligibility Standards

Program Guidance

Clients must be screened for program eligibility annually.

Limitations

Clients eligible for the Part A Program are medically underserved individuals diagnosed with HIV.

Requirements

Initial Determination

- Upon initiation of services, Ryan White Service Providers must determine whether an applicant meets the following Ryan White Program Eligibility Criteria:
    - Have a diagnosis of HIV;
    - Provide documentation of applicable county residency; and
    - Provide complete and accurate income documentation.
- Only needs to happen once initially.
- Required Documentation:
    - HIV/AIDS diagnosis
    - Proof of Residence
    - Proof of Income
    - Proof of Insurance

Annual Recertification

- Following approval of initial eligibility, clients must be screened for program eligibility every year to continue receiving Ryan White Program assistance.
- **Must** be completed yearly or as client circumstances change.
- Required Documentation:
    - Proof of Residence
    - Proof of Income
    - Proof of Insurance

Documentation

HIV/AIDS Diagnosis

Documentation needs to be submitted once at the Initial Determination. Documentation **must** be saved in the client's primary medical record.

Allowable Documentation:

- Laboratory Documentation
    - Proof of HIV may be found in laboratory test results that bear the client's name.
    - Examples include:

        - Positive result from HIV screening test (HIV 1/2 Combo Ab/Ag enzyme immunoassay [EIA]);
        - Positive result from an HIV 1 RNA qualitative virologic test such as a HIV 1 Nucleic Acid Amplification Test (NAAT);
        - Detectable quantity from an HIV 1 RNA quantitative virologic test (e.g. viral load test)
            - HIV.gov's Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring defines the level of detection to be greater than 20 copies/mL.[1]
            - CDC Articles indicate the lowest detectable quantity is 20-50 copies/mL.[2]
- Other Forms of Documentation
    - A statement or letter signed by a medical professional (acceptable signatories listed below) indicating that the individual diagnosed with HIV, including the individual's name and the phone number of the medical professional.
    - A medical progress note, hospital discharge paperwork, or other document signed by a medical professional (acceptable signatories listed below) indicating that the individual diagnosed with HIV, including the individual's name and the phone number of the medical professional.
    - An anonymous HIV test result containing identifying information sufficient to ensure a reasonable certainty as to the identity of the test subject, e.g. gender and date of birth (valid for only 60 days from the start of services at the agency).
    - A Texas Department of Criminal Justice (TDJC) physician-completed Medical Certification Form (MCF).
    - Acceptable signatories:
        - A licensed Physician.
        - A licensed Physician Assistant.
        - A licensed Nurse Practitioner.
        - A Registered Nurse working under the supervision of a Physician.
        - A licensed Master's Level Social Worker (LMSW) working under the supervision of a Physician.
        - An Advanced Practice Nurse.

Proof of Residence

Clients **must** be a resident of the TGA which consists of Bexar, Comal, Guadalupe, or Wilson Counties to be eligible for Part A services.

Documentation needs to be submitted at the Initial Determination and the Annual Recertification. Documentation **must** be saved in the client's primary medical record.

[1] Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring, Updated May 1, 2014 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring?view=full

[2] Guidance on Community Viral Load, 2011 https://stacks.cdc.gov/view/cdc/28147 (<50 copies/mL); Report of the NIH Panel to Define Principles of Therapy of HIV Infection (1998) https://www.cdc.gov/mmwr/preview/mmwrhtml/00052295.htm

Allowable Documentation:

- Valid (unexpired) Texas Driver's License noting Texas address;
- Texas State identification card (including identification from criminal justice systems);
- Recent Social Security, Medicaid/Medicare or Food Stamp/TANF benefit award letters in name of client showing address;
- IRS Tax Return Transcript, Verification of Non-Filing, W2, or 1099;
- Current employment records (pay stub);
- Post office records;
- Current voter registration;
- A mortgage or official rental lease agreement in the client's name;
- Valid (unexpired) motor vehicle registration;
- Proof of current college enrollment or financial aid;
- Students from another state who are living in Texas to attend school may claim Texas residency based on their student status while they are residing in Texas;
- Any bill in the client's name for a service connected to a physical address (client's place of residency) dated within one month of the month of application (e.g. bills for rent, mortgage, electric, gas, water, trash, cable, landline phone, etc.);
- A letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals; or
- A statement/attestation (does not require notarization) with client's signature declaring that client has no resources for housing or shelter.

Proof of Income

Income **must** be less than 300% of Federal Poverty Level (FPL) for a client to be eligible for Part A services.

Documentation needs to be submitted at the Initial Determination and the Annual Recertification. Documentation **must** be saved in the client's primary medical record.

The client's primary record **must** contain the Proof of Income Documentation **and** the Income Calculation Worksheet.

Allowable Documentation:

- Pay stubs (30 continuous days of payment within the last 60 days);
- Supporter statement;
- Employer statement;
- Agency letter;
- Social Security Income (SSI) Award Letter;
- Social Security Disability Income (SSDI) Award Letter;
- Other income documentation;
- Texas Workforce Commission unemployment benefits letter; or
- Prison release paper within 30 days of release date.

Subrecipients and providers must use the DSHS provided Income Calculation Worksheet (XLS) to calculate an applicant's income. These worksheets can be found online on the MAGI documents page.

- The *Income Calculation Worksheet* is divided into 'Section A' and 'Section B'. This form calculates an individual's FPL based on their modified adjusted gross income (MAGI).
- Section A is used to calculate:
    - Income for clients who do not have access to a 'Tax Return Transcript' or other standardized tax return forms (form 1040, 1040 EZ, etc.);
    - Income for clients whose income has changed since filing taxes for the most recent year; and
    - Clients who are 'Married Filing Jointly'.
- Documents that may be used to complete Section A are outlined below:
    - Pay stubs (30 continuous days of payment within the last 60 days);
    - Supporter statement;
    - Employer statement;
    - Agency letter;
    - Social Security Income (SSI) Award Letter;
    - Social Security Disability Income (SSDI) Award Letter;
    - DSHS Self-employment log; or
    - Other income documentation.

Note: If the client is unable to provide any other form of income documentation, bank statements are acceptable forms of income documentation for both the Part A Program.

- Section B is used to calculate income for clients who have access to the following:
    - Standardized tax return forms (form 1040, 1040 EZ, Tax Return Transcript, etc.).
- The *Income Calculation Worksheet* is self-calculating and produces the FPL percentage based on both household and individual income.
    - A copy of the worksheet and supporting documentation must be kept in the primary client record.

Proof of Insurance

Documentation needs to be submitted at the Initial Determination and the Annual Recertification. Documentation **must** be saved in the client's primary medical record.

The client's primary record **must** contain the Proof of Insurance Documentation **and** the AA created *Health Insurance Verification Form*.

Allowable Documentation:

- Uninsured or underinsured status (insurance verification as proof).
- Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare.

- For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare.
- Proof of compliance with eligibility determination as defined by the State or ADAP.
- Documentation of eligibility status must be filed in the client's primary record.
- Acceptable documentation to verify Medicaid/Medicare or third party eligibility status:
    - AA created *Health Insurance Verification Form* to be used for Client self-attestation of no change or self-attestation of change with acceptable documentation.
        - Form must be uploaded into Ryan White Data System with the document source name and supporting documents.
        - For example:
            - *Health Insurance Verification Form*, with necessary documentation, and/or health insurance card information; or
            - *"ABC" agency form*, with necessary documentation, and/or health insurance card information.
    - The preferred method for documenting insurance verification is printing the results and filing in client record or electronically in an organized and identifiable manner.
    - Verification of employment, i.e. payroll stub, copy of payroll check, bank statement showing direct payroll deposit, letter from employer on company letterhead indicating weekly or monthly wages no greater than 6 months old (to demonstrate Medicaid/Medicare or third-party eligibility status).
    - Medicaid/Medicare or third party rejection/denial letter covering the dates of service.
    - Change Healthcare Holdings, Inc. forms or other automated system (must be done at least monthly).
    - The following documentation is acceptable only for homeless clients:
        - Letter on company letterhead from a case manager, social worker, counselor or other professional (certifying Medicaid/Medicare or third-party eligibility status) from another agency who has personally provided services to the client, stating that the client is undocumented and/or homeless.

Note: HRSA does not require documentation to be provided in-person nor be notarized. Clients may submit and sign documentation electronically.[3]

[3] HRSA Policy Clarification Notice (PCN) 21-02 Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program and HRSA Dear Colleague Letter for PCN 21-02

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Initial Eligibility Determination	
Standard	Monitoring Indicators
Eligibility determination of clients to determine eligibility as specified by the jurisdiction.	Indicator 1: Percentage of clients with documentation of HIV/AIDS diagnosis in the client file of completion of initial eligibility determination. Indicator 2: Percentage of clients with proof of residence in the client file of completion of initial eligibility determination. Indicator 3: Percentage of clients with proof of low income in the client file of completion of initial eligibility determination. Indicator 4: Percentage of clients with a completed income calculation worksheet in the client primary record. Indicator 5: Percentage of clients with proof of insurance (insurance verification) in the client file of completion of initial eligibility determination. Indicator 6: Percentage of clients with a completed AA created Health Insurance Verification Form in the client primary record.

Section B: Annual Eligibility Recertification	
Standard	Monitoring Indicators
Eligibility reassessment of clients to determine eligibility as specified by the jurisdiction.	Indicator 7: Percentage of clients with proof of residence in the client file of completion of annual eligibility determination. Indicator 8: Percentage of clients with proof of low income in the client file of completion of annual eligibility determination. Indicator 9: Percentage of clients with a completed income calculation worksheet in the client primary record.

	Indicator 10: Percentage of clients with proof of insurance (insurance verification) in the client file of completion of annual eligibility determination. Indicator 11: Percentage of clients with a completed AA created Health Insurance Verification Form in the client primary record.

Section C: Verification of Payer of Last Resort (PoLR)	
Standard	Monitoring Indicators
Funds may not be used for payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service under any state compensation program, insurance policy, federal or state health benefits program or by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).	Indicator 12: Percentage of clients accessing Ryan White Part A services that have documented evidence of screening completed of other resources for services in the primary client record.

References

PHS Act

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 21-02: Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program October 2021 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Program Letters: HRSA Dear Colleague Letter for PCN 21-02 October 2021 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program Part A Manual Revised 2013 (PDF)

University Health Ryan White Program Administration Policy: 4.00 Eligibility & PoLR for the Part A & MAI Program

Ryan White MAI Eligibility Standards

Program Guidance

Clients must be screened for program eligibility annually.

Limitations

Clients eligible for the MAI Program are medically underserved minorities, specifically Hispanic/Latino and Black/African Americans diagnosed with HIV.

Requirements

Initial Determination

- Upon initiation of services, Ryan White Service Providers must determine whether an applicant meets the following Ryan White Program Eligibility Criteria:
    - Have a diagnosis of HIV;
    - Provide documentation of applicable county residency; and
    - Provide complete and accurate income documentation.
- Only needs to happen once initially.
- Required Documentation:
    - HIV/AIDS diagnosis
    - Proof of Residence
    - Proof of Income
    - Proof of Insurance

Annual Recertification

- Following approval of initial eligibility, clients must be screened for program eligibility every year to continue receiving Ryan White Program assistance.
- **Must** be completed yearly or as client circumstances change.
- Required Documentation:
    - Proof of Residence
    - Proof of Income
    - Proof of Insurance

Documentation

HIV/AIDS Diagnosis

Documentation needs to be submitted once at the Initial Determination. Documentation **must** be saved in the client's primary medical record.

Allowable Documentation:

- Laboratory Documentation
    - Proof of HIV may be found in laboratory test results that bear the client's name.
    - Examples include:
        - Positive result from HIV screening test (HIV 1/2 Combo Ab/Ag enzyme immunoassay [EIA]);

        - Positive result from an HIV 1 RNA qualitative virologic test such as a HIV 1 Nucleic Acid Amplification Test (NAAT);
        - Detectable quantity from an HIV 1 RNA quantitative virologic test (e.g. viral load test)
            - HIV.gov's Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring defines the level of detection to be greater than 20 copies/mL.[4]
            - CDC Articles indicate the lowest detectable quantity is 20-50 copies/mL.[5]
- Other Forms of Documentation
    - A statement or letter signed by a medical professional (acceptable signatories listed below) indicating that the individual diagnosed with HIV, including the individual's name and the phone number of the medical professional.
    - A medical progress note, hospital discharge paperwork, or other document signed by a medical professional (acceptable signatories listed below) indicating that the individual diagnosed with HIV, including the individual's name and the phone number of the medical professional.
    - An anonymous HIV test result containing identifying information sufficient to ensure a reasonable certainty as to the identity of the test subject, e.g. gender and date of birth (valid for only 60 days from the start of services at the agency).
    - A Texas Department of Criminal Justice (TDJC) physician-completed Medical Certification Form (MCF).
    - Acceptable signatories:
        - A licensed Physician.
        - A licensed Physician Assistant.
        - A licensed Nurse Practitioner.
        - A Registered Nurse working under the supervision of a Physician.
        - A licensed Master's Level Social Worker (LMSW) working under the supervision of a Physician.
        - An Advanced Practice Nurse.

Proof of Residence

Clients **must** be a resident of the TGA which consists of Bexar, Comal, Guadalupe, or Wilson Counties to be eligible for MAI services.

Documentation needs to be submitted at the Initial Determination and the Annual Recertification. Documentation **must** be saved in the client's primary medical record.

Allowable Documentation:

- Valid (unexpired) Texas Driver's License noting Texas address;

[4] Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring, Updated May 1, 2014 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring?view=full

[5] Guidance on Community Viral Load, 2011 https://stacks.cdc.gov/view/cdc/28147 (<50 copies/mL); Report of the NIH Panel to Define Principles of Therapy of HIV Infection (1998) https://www.cdc.gov/mmwr/preview/mmwrhtml/00052295.htm

- Texas State identification card (including identification from criminal justice systems);
- Recent Social Security, Medicaid/Medicare or Food Stamp/TANF benefit award letters in name of client showing address;
- IRS Tax Return Transcript, Verification of Non-Filing, W2, or 1099;
- Current employment records (pay stub);
- Post office records;
- Current voter registration;
- A mortgage or official rental lease agreement in the client's name;
- Valid (unexpired) motor vehicle registration;
- Proof of current college enrollment or financial aid;
- Students from another state who are living in Texas to attend school may claim Texas residency based on their student status while they are residing in Texas;
- Any bill in the client's name for a service connected to a physical address (client's place of residency) dated within one month of the month of application (e.g. bills for rent, mortgage, electric, gas, water, trash, cable, landline phone, etc.);
- A letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals; or
- A statement/attestation (does not require notarization) with client's signature declaring that client has no resources for housing or shelter.

Proof of Income

Income **must** be less than 300% of Federal Poverty Level (FPL) for a client to be eligible for MAI services.

Documentation needs to be submitted at the Initial Determination and the Annual Recertification. Documentation **must** be saved in the client's primary medical record.

The client's primary record **must** contain the Proof of Income Documentation **and** the Income Calculation Worksheet.

Allowable Documentation:

- Pay stubs (30 continuous days of payment within the last 60 days);
- Supporter statement;
- Employer statement;
- Agency letter;
- Social Security Income (SSI) Award Letter;
- Social Security Disability Income (SSDI) Award Letter;
- Other income documentation;
- Texas Workforce Commission unemployment benefits letter; or
- Prison release paper within 30 days of release date.

Subrecipients and providers must use the DSHS provided Income Calculation Worksheet (XLS) to calculate an applicant's income. These worksheets can be found online on the MAGI documents page.

- The *Income Calculation Worksheet* is divided into 'Section A' and 'Section B'. This form calculates an individual's FPL based on their modified adjusted gross income (MAGI).
- Section A is used to calculate:
    - Income for clients who do not have access to a 'Tax Return Transcript' or other standardized tax return forms (form 1040, 1040 EZ, etc.);
    - Income for clients whose income has changed since filing taxes for the most recent year; and
    - Clients who are 'Married Filing Jointly'.
- Documents that may be used to complete Section A are outlined below:
    - Pay stubs (30 continuous days of payment within the last 60 days);
    - Supporter statement;
    - Employer statement;
    - Agency letter;
    - Social Security Income (SSI) Award Letter;
    - Social Security Disability Income (SSDI) Award Letter;
    - DSHS Self-employment log; or
    - Other income documentation.

Note: If the client is unable to provide any other form of income documentation, bank statements are acceptable forms of income documentation for both the Part A Program.

- Section B is used to calculate income for clients who have access to the following:
    - Standardized tax return forms (form 1040, 1040 EZ, Tax Return Transcript, etc.).
- The *Income Calculation Worksheet* is self-calculating and produces the FPL percentage based on both household and individual income.
    - A copy of the worksheet and supporting documentation must be kept in the primary client record.

Proof of Insurance

Documentation needs to be submitted at the Initial Determination and the Annual Recertification. Documentation **must** be saved in the client's primary medical record.

The client's primary record **must** contain the Proof of Insurance Documentation **and** the AA created *Health Insurance Verification Form*.

Allowable Documentation:

- Uninsured or underinsured status (insurance verification as proof).
- Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare.

- For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare.
- Proof of compliance with eligibility determination as defined by the State or ADAP.
- Documentation of eligibility status must be filed in the client's primary record.
- Acceptable documentation to verify Medicaid/Medicare or third party eligibility status:
    - AA created *Health Insurance Verification Form* to be used for Client self-attestation of no change or self-attestation of change with acceptable documentation.
        - Form must be uploaded into Ryan White Data System with the document source name and supporting documents.
        - For example:
            - *Health Insurance Verification Form*, with necessary documentation, and/or health insurance card information; or
            - *"ABC" agency form*, with necessary documentation, and/or health insurance card information.
    - The preferred method for documenting insurance verification is printing the results and filing in client record or electronically in an organized and identifiable manner.
    - Verification of employment, i.e. payroll stub, copy of payroll check, bank statement showing direct payroll deposit, letter from employer on company letterhead indicating weekly or monthly wages no greater than 6 months old (to demonstrate Medicaid/Medicare or third-party eligibility status).
    - Medicaid/Medicare or third party rejection/denial letter covering the dates of service.
    - Change Healthcare Holdings, Inc. forms or other automated system (must be done at least monthly).
    - The following documentation is acceptable only for homeless clients:
        - Letter on company letterhead from a case manager, social worker, counselor or other professional (certifying Medicaid/Medicare or third-party eligibility status) from another agency who has personally provided services to the client, stating that the client is undocumented and/or homeless.

Note: HRSA does not require documentation to be provided in-person nor be notarized. Clients may submit and sign documentation electronically.[6]

[6] HRSA Policy Clarification Notice (PCN) 21-02 Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program and HRSA Dear Colleague Letter for PCN 21-02

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Initial Eligibility Determination	
Standard	Monitoring Indicators
Eligibility determination of clients to determine eligibility as specified by the jurisdiction.	Indicator 1: Percentage of clients with documentation of HIV/AIDS diagnosis in the client file of completion of initial eligibility determination. Indicator 2: Percentage of clients with proof of residence in the client file of completion of initial eligibility determination. Indicator 3: Percentage of clients with proof of low income in the client file of completion of initial eligibility determination. Indicator 4: Percentage of clients with a completed income calculation worksheet in the client primary record. Indicator 5: Percentage of clients with proof of insurance (insurance verification) in the client file of completion of initial eligibility determination. Indicator 6: Percentage of clients with a completed AA created Health Insurance Verification Form in the client primary record.

Section B: Annual Eligibility Recertification	
Standard	Monitoring Indicators
Eligibility reassessment of clients to determine eligibility as specified by the jurisdiction.	Indicator 7: Percentage of clients with proof of residence in the client file of completion of annual eligibility determination. Indicator 8: Percentage of clients with proof of low income in the client file of completion of annual eligibility determination. Indicator 9: Percentage of clients with a completed income calculation worksheet in the client primary record.

	Indicator 10: Percentage of clients with proof of insurance (insurance verification) in the client file of completion of annual eligibility determination. Indicator 11: Percentage of clients with a completed AA created Health Insurance Verification Form in the client primary record.

Section C: Verification of Payer of Last Resort (PoLR)	
Standard	Monitoring Indicators
Funds may not be used for payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service under any state compensation program, insurance policy, federal or state health benefits program or by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).	Indicator 12: Percentage of clients accessing Ryan White MAI services that have documented evidence of screening completed of other resources for services in the primary client record.

References

PHS Act

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 21-02: Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program October 2021 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Program Letters: HRSA Dear Colleague Letter for PCN 21-02 October 2021 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program Part A Manual Revised 2013 (PDF)

University Health Ryan White Program Administration Policy: 4.00 Eligibility & PoLR for the Part A & MAI Program

Services Standards

AIDS Pharmaceutical Assistance (Local) {LPAP}

HRSA Service Category Description

Core Service Category

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

Program Guidance

An LPAP is a program to ensure that clients 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. Part A grant funds may be used to support an LPAP. ADAP funds may not be used for LPAP support.

Services

LPAP funds may be used to cover medications that are on the LPAP Formulary and long-term medications (more than 60 days). LPAP funds may cover medications for clients who were denied ADAP.

LPAP medications must be purchased at the lowest possible cost, such as 340B Program pricing. Clients must obtain their medications through a 340B covered entity or pharmacy OR a comparable medication discount program. Contracts/Memoranda of Understanding (MOU) must be set up to purchase medications at wholesale or another below retail price.

Prescribed Over-the-Counter (OTC) medications may be purchased with LPAP funds if the medication is listed on the LPAP formulary and the provider has deemed that the medication is needed for prevention and treatment of opportunistic infections or to prevent the serious deterioration of health. All OTC medications purchased with LPAP funds must be FDA approved.

All LPAP programs will use the statement of need and available standards of care to inform their services and will operate in accordance with legal and ethical standards. The importance of maintaining confidentiality is critical and all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards.

Limitations

Clients cannot be enrolled in another medication assistance program for the same medication, excluding co-payment discounts.

LPAP funds are not to be used for emergency or short-term medications; the Emergency Financial Assistance (EFA) service category may assist with short-term medication assistance not covered by the LPAP.

Medications not included in the LPAP formulary cannot be purchased with LPAP funds. All medications purchased with LPAP funds must be FDA-approved. The provider wishing to prescribe a medication not on the formulary shall make a request to the LPAP Formulary Committee for approval to add the medication to the formulary. The medication may only be purchased using LPAP funds after being added to the formulary. The Emergency Financial Assistance (EFA) service category may assist with the purchase of medications not on the LPAP Formulary while the medication is being reviewed by the LPAP Formulary Committee for inclusion in the LPAP Formulary.

Local pharmacy assistance programs are not funded with ADAP earmark funding. LPAPs are not to take the place of the ADAP program.

Statement of Need

The Texas ADAP (TX ADAP) has a limited formulary and currently limits income eligibility to 200% of the Federal Poverty Limit (FPL), with a spend-down adjustment to account for the cost of HIV medications. Providers must first use client and/or pharmaceutical assistance programs (PAP) prior to the use of LPAP. However, these programs may not fully meet the needs of clients with HIV-related medication needs because the full spectrum of HIV and HIV-related medications that may be prescribed to improve health outcomes may not be affordable or available via a PAP. The LPAP is needed to assist clients that have incomes above 200% of FPL, after spend-down adjustment. LPAP is further needed to assist clients requiring long-term HIV and HIV-related medications that cannot be obtained through the TX ADAP program or PAPs.

The TX ADAP must be accessed by eligible clients prior to using the LPAP.

- The LPAP may not duplicate services available through the TX ADAP program.
- Clients needing long-term assistance with prescription medications shall be assisted with completing a TX ADAP application and, when applicable, PAP applications.
- If the medication is not on the TX ADAP formulary and is not available through assistance programs, the client may be served with LPAP funds if the medication is on the LPAP formulary.
- If short-term medication assistance is required and a client is eligible, this need may be met with Emergency Financial Assistance funds.
- Clients with insurance and other third-party payer sources are not eligible for LPAP assistance unless there is documentation on file that the medication is not covered by their prescription benefits.

Purchase of pharmaceuticals must be directly linked to the management of HIV that is:

- Consistent with the most current HIV/AIDS Treatment Guidelines;
- Coordinated with the State's Part B Texas HIV Medication Program (THMP) of which the TX ADAP is part of; and/or
- Implemented in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program.

LPAP shall, to the extent allocations permit, provide eligible clients with medications on the local area's LPAP formulary that have been prescribed by a qualified, prescribing medical provider. Clients denied enrollment into the THMP may access medications on the ADAP formulary via LPAP only if other payer sources have been exhausted and the medication is on the local area's LPAP formulary.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Local Drug Reimbursement	Per prescription (not pill or dose)

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: LPAP Prescriptions	
Standard	Monitoring Indicators
Providers may use funding to assist eligible clients with purchasing medications that are over the Medicaid monthly allotment or that the THMP program does not cover. A copy of the client's prescription from the prescribing provider is on file with the agency. The prescription must include: • Name of the client • Date of Birth • Medication • Dose • Signature of prescribing medical provider	Indicator 1: Percentage of clients with documentation that the LPAP is not dispensing medications as a result or component of a primary medical visit. Indicator 2: Percentage of clients with documentation that the LPAP is not dispensing medications as a single occurrence of short duration (an emergency). Indicator 3: Percentage of clients with documentation that the LPAP is not dispensing medications while awaiting ADAP eligibility determination. Indicator 4: Percentage of clients with documentation that the LPAP is not dispensing medications by vouchers to clients on a single occurrence. Indicator 5: Percentage of client that have the documented prescriptions funded through LPAP assistance with name of client; date of birth; medication; dose; and signature of prescribing medical provider.

Section B: Timeliness of Services	
Standard	Monitoring Indicators
Agencies must have a system for clients to access prescriptions. Prescriptions should be available and approved for LPAP assistance within two (2) business days. Otherwise eligible clients shall have ongoing access to medications prescribed by a qualified prescribing medical provider through the local area's LPAP program so long as the medication is on the LPAP formulary and allocations permit.	Indicator 6: Percentage of clients with documentation that they have access to their prescribed medication(s) within two (2) business days of approved LPAP-funding.

Section C: Prescribed Over the Counter (OTC) Medications	
Standard	Monitoring Indicators
LPAP can assist clients with their OTC medications if the provider has prescribed the medication and has deemed the medication is needed for prevention and treatment of opportunistic infections or to prevent the serious deterioration of the client's health AND the medication is on the LPAP formulary.	Indicator 7: Percentage of clients prescribed OTC medications paid through LPAP funding have documented evidence of medical necessity from prescribing provider.

Section D: Medication Adherence Counseling	
Standard	Monitoring Indicators
Clients are offered counseling on medication adherence when assistance is requested.	Indicator 8: Percentage of clients who have documented evidence of adherence counseling offered at the time of assistance request.

Section E: Viral Suppression	
Standard	Monitoring Indicators
Clients who access HIV medications for long-term assistance (more than 60 days) have documentation in their files of viral suppression.	Indicator 9: Percentage of clients accessing HIV antiviral medication assistance for long-term (more than 60 days) have documented evidence of viral suppression within the measurement year.

References

PHS Act § 2604(c)(3)(C)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Program Letters: Local Pharmaceutical Assistance Programs (LPAP) Clarification 08/29/2013 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Texas Administrative Code Title 22; Chapter 15, 291.6

DSHS HIV/STD Program Policies. Payer of Last Resort (Policy 590.001)

DSHS HIV/STD Program Policies Purchasing Prescription or Over-The-Counter Medications and Vitamins not Covered by a Third-Party Payer. (Policy 220.101)

DSHS HIV/STD Program Policies HIV/STD Medication Program Pharmacy Eligibility Criteria. (Policy 700.003)

Early Intervention Services (EIS)

HRSA Service Category Description

Core Service Category

Early Intervention Services is defined in the Public Health Services (PHS) Act § 2651(e) as the following, with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services:

A. counseling individuals with respect to HIV/AIDS;
B. testing individuals with respect to HIV/AIDS, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from HIV/AIDS;
C. referrals of individuals with HIV/AIDS to appropriate providers of health and support services;
D. other clinical and diagnostic services regarding HIV/AIDS, and periodic medical evaluations of individuals with HIV/AIDS; and
E. providing the therapeutic measures through a system of linkages to community-based primary care providers.

Program Guidance

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

Ryan White Part A and MAI Programs EIS services **must** include the following four components:

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

Note: All four components **must** be present in the Subrecipient's EIS program.

Services

EIS services are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system. EIS services require coordination with providers of prevention services and should be provided at specific points of entry.

Counseling, testing, and referral activities are designed to bring individuals with HIV into Outpatient/Ambulatory Health Services (OAHS). The goal of EIS is to decrease the number of underserved individuals with HIV by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found not to have HIV should be referred to appropriate prevention services.

Limitations

Ryan White Part A and MAI funds are used for HIV testing only where existing federal, state, and local funds are not adequate and RWHAP funds will supplement, not supplant, existing funds for testing.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Early Intervention Service	Per encounter with client previously unlinked to care

If the client is currently linked to or active in care, then the client is **not** an EIS client. If Care Coordination is needed for the client, they should receive Medical Case Management (MCM), Non-Medical Case Management (NMCM), or Referral for Healthcare and Support Services (RHSS) services.

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: HIV Testing and Results Counseling	
Standards Requirement	Monitoring Indicators
Agencies providing HIV testing will ensure the following: • Staff will be familiar with the DSHS HIV/STD Policy 2013.02; • At a minimum, ensure that HIV testing is performed through the use of blood samples (either finger stick or venipuncture); • Maintain records of number of HIV tests conducted in each measurement year; and • Maintain records of test results with documentation that indicates whether the client was informed of their status. Results counseling will be offered to all clients regardless of the result of the HIV test performed. Results counseling will include discussion of risk reduction education and general health education provided to the client. Results counseling for people living with HIV will include: • Health education regarding HIV • Risk Reduction counseling • Maintenance of immune system • Disclosure to partners and support systems • Importance of accessing medical care and medications. Results counseling for HIV-negative individuals will include: • Health education • Risk Reduction • Referral to HIV prevention services	Indicator 1: Percentage of clients offered results counseling as documented in the primary client record. Indicator 2: Percentage of HIV positive tests in the measurement year. (HRSA HAB Measure) Indicator 3: Percentage of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year. (HRSA HAB Measure) Indicator 4: Percentage of individuals who test positive are referred and linked to healthcare and supportive services. Indicator 5: Percentage of individuals who test positive are provided wealth education and literacy training, enabling clients to navigate the HIV system.

Section B: Linkage to Care	
Standards Requirement	Monitoring Indicators
Clients testing positive for HIV through preliminary testing will be linked to and assisted in scheduling an appointment with a medical provider of the client's choosing. Successful linkage to outpatient/ambulatory health services is measured as attendance to the actual medical appointment with a prescribing provider.	Indicator 6: Percentage of clients who tested positive who were linked to outpatient/ambulatory health services in the measurement year. Indicator 7: Percentage of people living with HIV who attended a routine HIV medical care visit within 1 month of HIV diagnosis. (HRSA HAB Measure) Indicator 8: Percentage of people living with HIV, who were homeless or unstably housed in the measurement period, who attended a routine HIV medical care visit within three (3) months of HIV diagnosis. (HRSA HAB Measure)

Section C: EIS Care Planning	
Standards Requirement	Monitoring Indicators

Persons living with HIV will have care plans developed during the time they are receiving services through EIS programs. Care plans will include:
• Problem Statement (Need)
• Goal(s) – suggest no more than 3 goals
• Intervention
  ○ Task(s)
  ○ Referral(s)
  ○ Service Deliveries
• Individuals responsible for the activity (EIS staff, client, family)
• Anticipated time for each task
 	
The care plan is updated with outcomes and revised or amended in response to changes in the client's life circumstances or goals.
 	
As EIS programs are centered to assist clients in engaging in medical care rapidly after testing positive, care plans should be updated at least monthly, or more often as goals are achieved.
	Indicator 9: Percentage of clients that have a care plan developed as documented in the primary client record.
	
	Indicator 10: Percentage of clients that have a care plan updated and/or revised as documented in the primary client record.

Section D: Progress Notes	
Standards Requirement	Monitoring Indicators
Progress notes will be maintained in each client's primary record with documentation of the assistance the EIS staff provided to the client to help achieve the goal of a successful linkage to OAHS services.	Indicator 11: Percentage of clients that have documented progress notes showing assistance provided to the client in the primary client record.

Section E: Referral and Follow-Up	
Standards Requirement	Monitoring Indicators
EIS staff will assist the clients with referrals to necessary services to achieve successful linkage to care. Referrals will be documented in the client's primary record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable • Any additional services necessary to help clients engage in their medical care All referrals made will have documentation of follow-up to the referral in the client's primary record.	Indicator 12: Percentage of clients with documented referrals in the primary client record initiated in a timely manner with client agreed participation upon identification of client needs. Indicator 13: Percentage of clients with documented referrals declined by the client in the primary client record. Indicator 14: Percentage of clients that have documentation of follow-up to the referral including appointment attended and the result of the referral in the primary client record.

Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS staff offered to the client.	

Section F: Transition/Case Closure	
Standards Requirement	Monitoring Indicators
Clients who are successfully linked to active MCM services and/or OAHS must have their cases closed with a case closure summary narrative documented on the criteria and protocol outlined below. Common reasons for case closure, as applicable, include: • Client is referred and successfully linked to MCM services; • Client relocates outside of the service area; • Client chooses to terminate services; • Client is lost to care or does not engage in services; • Client incarceration is greater than six (6) months in a correctional facility; • Client death. Transition criteria: • Client has completed EIS goals and has been successfully linked to MCM services • Client is no longer in need of EIS services (client declines EIS assistance). Client is considered non-adherent with care if three (3) attempts to contact client (via phone, text, home visit, email, and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Case closure proceedings should be initiated by the agency 30 days following the 3rd attempt. *Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of Texas Medical Record Privacy Act HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, email, certified letter) when trying to re-engage a client, as appropriate. *Agencies must ensure that they have releases of information and consent forms that meet the requirements of Texas Medical Record Privacy Act HB 300 regarding the electronic dissemination of PHI.*	Indicator 15: Percentage of clients with closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary) in the primary client record system. Indicator 16: Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable).

References

PHS Act §§ 2604(c)(3)(E) and (e), and 2651(e)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

DSHS HIV/STD Policy 2013.02, The Use of Testing Technology to Detect HIV Infection. Revision date September 3, 2014. Accessed on October 12, 2020.

Emergency Financial Assistance (EFA)

HRSA Service Category Description

Support Service Category

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

Program Guidance

It is expected that all other sources of funding in the community for EFA will be effectively used and that any allocation of RWHAP funds for these purposes will be as the Payor of Last Resort (PoLR), and for limited amounts, uses, and periods of time.

EFA funds used to pay for otherwise allowable HRSA Ryan White Program services must be accounted for under the EFA category.

Services

Ryan White Part A Program funds may be used to provide services in the following categories:

1. ADAP eligibility determination period; and
2. Emergency Financial Assistance (EFA).

EFA can be used during the ADAP eligibility determination period. EFA can be used to reimburse dispensing fees associated with purchased medications.

The Subrecipient 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.

EFA provides funding through:

- Short-term payments to agencies
- Establishment of voucher programs

EFA to individual clients is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used.

EFA funds may be used on the following essential items or services.

- Utilities (may include household utilities such as gas, electricity, propane, water, and all required fees).
- Housing (may include as rent or temporary shelter. EFA can only be used if Operation BRAVE Housing Services and/or HOPWA assistance is not available or if client is not eligible for Operation BRAVE Housing Services and/or HOPWA services).
- Food (groceries or food vouchers)
- Transportation
- Prescription medication assistance such as short term, one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit (not to exceed a 30-day supply)
- Other RWHAP allowable costs needed to improve health outcomes

Limitations

Direct cash payments to clients are not permitted.

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

Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Emergency Assistance - Prescription	Per prescription
Emergency Assistance – Utilities	Per transaction
Emergency Assistance – Food	Per visit

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Assisting Clients during ADAP eligibility determination period	
Standards Requirement	Monitoring Indicators
RWHAP-eligible clients with documented evidence of emergency need of HIV medications are able to receive short-term medication assistance (30-day supply) with limited use of EFA for no more than 60 days (2 months or less).	Indicator 1: Percentage of clients that have documented evidence in the client primary record of short-term HIV medication assistance provided during ADAP application period.

Section B: Assisting Clients with Short-Term Medications	
Standards Requirement	Monitoring Indicators
RWHAP-eligible clients with documented evidence of pending health insurance medication plan approval are able to receive short-term HIV medication assistance through EFA.	Indicator 2: Percentage of clients that have documented evidence in the client primary record of short-term HIV medication assistance provided during health insurance application period.

Section C: Client Determination for Emergency Financial Assistance	
Standards Requirement	Monitoring Indicators
Applicants must demonstrate an urgent need resulting in their inability to pay their utility bills or prescriptions without financial assistance for essential items or services necessary to improve health outcomes. For example, demonstrated need may be demonstrated by but not limited to the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • They are unable to provide for basic needs and shelter • A failure to provide EFA will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the agency Agency staff will conduct an assessment of the presenting problems/needs of the client with the emergency financial issue. A service plan will be developed documenting client's emergent need resulting in their inability to pay bills/prescriptions without assistance, and other resources pursued noted prior to using EFA funding for assistance. Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. Resolution of the emergency status will be documented in the client record.	Indicator 3: Percentage of clients with documented evidence of determination of EFA need noted in client's primary record. Indicator 4: Percentage of clients provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the recipient. Indicator 5: Percentage of clients provided assistance only for the following essential services: utilities, housing, food (including groceries and food vouchers), transportation, and medication. Indicator 6: Percentage of clients with documented service plan for EFA in the client's primary record that indicates emergent need, other resources pursued, and outcome of EFA provided. Indicator 7: Percentage of clients with documented evidence of resolution of the emergency status and referrals made (as applicable) with outcome results in client's primary record.

Section D: Emergency Financial Assistance Provided	
Standards Requirement	Monitoring Indicators
Short-term assistance will only be provided for: • Utilities • Housing • Food (groceries and food vouchers) • Transportation • Prescription medication assistance • Other RWHAP-allowable costs needed to improve health outcomes All completed requests for assistance shall be approved or denied within three (3) business days. Assistance shall be issued in response to an essential need (as identified by the staff person providing EFA) within three (3) business days of approval of request. Payment for assistance made to service providers will protect client confidentiality. Use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.	Indicator 8: Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients. Indicator 9: Percentage of clients with documented evidence of payments made by agency for resolution of emergency status. (*copies of checks/vouchers available*) Indicator 10: Percentage of clients with documented evidence that Ryan White Program is the payor of last resort in the client file.

References

PHS Act § 2604(d)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Food Bank (FB) / Home Delivered Meals

HRSA Service Category Description

Support Service Category

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

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

Program Guidance

Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the Ryan White Part A Program and if offered, should be funded under the core medical service Medical Nutritional Therapy (MNT).

Services

This category includes the provision of actual food, prepared meals, or food vouchers to purchase prepared meals. This category also includes the provision of fruit, vegetables, dairy, canned meat, staples, and personal care products in a food bank setting.

Food Bank: Food Bank services are the provision of actual food and personal care items in a food bank setting.

On-site/Home-Delivered Meals: On-site/Home-Delivered Meals are the provision of prepared meals or food vouchers for prepared meals, in either a congregate dining setting or delivered to clients who are homebound and cannot shop for or prepare their own food. This service includes the provision of both frozen and hot meals.

Limitations

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

Food vouchers/gift cards are to be restricted from the purchase of tobacco or alcohol products. No direct payment to clients is allowed.

Taxonomy

The following taxonomy are the allowable “Subcategory” and “Service Units” that are to be used in the e2SanAntonio, the Recipient’s Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Food Pantry/Voucher Visit Without Nutritional Supplements	Per visit
Food Pantry/Voucher Visit with Nutritional Supplements (Supplements ordered by a licensed dietician should be funded and recorded under Medical Nutritional Therapy)	Per visit
Meals - Home-Delivered	Per person per meal
Meals - Congregate	Per person per meal

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Provision of Services	
Standards Requirement	Monitoring Indicators
Clients referred to, or otherwise accessing food bank without a referral, must be screened for other eligible resources such as Supplemental Nutrition Assistance Program (SNAP) as evidence in their primary record. Clients accessing food bank have documentation in the client primary record of reason/need assessed. Assessment of client's immediate or ongoing need for food bank services is documented in the client's primary record.	Indicator 1: Percentage of clients with documentation in the client's primary record of other food resources accessed prior to clients accessing food bank. Indicator 2: Percentage of clients with documentation in the client's primary record of the assessment of need for food resources.

Section B: Dietary Guidance	
Standards Requirement	Monitoring Indicators
There is an agency plan to address the needs of clients' special diets. As applicable, clients are referred to an RD for specific dietary issues. If a client has a special diet, a Registered Dietician (RD) must be consulted in the development of a dietary/nutritional policy that lists specific food items that may be offered in the food bank/pantry or prepared for home-delivered meals. Clients are offered counseling, if requested, to help with meal planning and food appropriateness.	Indicator 3: Percentage of clients are referred, as applicable, to a RD for specific dietary issues as documentation in the client primary record. Indicator 4: Percentage of clients that are offered counseling for meal planning and food appropriateness.

Program must ensure that available foods are selected considering special nutritional needs (incorporating generally accepted nutritional standards), religious requirements, and ethnic food preferences, as appropriate. Attempts must be made on a regular basis to provide choices on food items that meet individual dietary needs of clients, including the foods that fall into the recognized food categories for good diet identified in the Food and Drug Administration or Academy of Nutrition and Dietetics.	

Section C: Home Cooked/Hot Meals	
Standards Requirement	Monitoring Indicators
Clients assessed for food security and offered home-cooked meals/hot meal programs have evidence of the need documented in the client's primary record.	Indicator 5: Percentage of clients accessing hot meal programs, have documented evidence of assessment of need in the client's primary record.

Section D: Discharge/Termination	
Standards Requirement	Monitoring Indicators
Agency will develop discharge/termination for cause criteria and procedures.	Indicator 6: Percentage of clients discharged from food bank/home-delivered meals have documentation of reason of discharge in the client's primary record.

References

PHS Act § 2604(d)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

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

HRSA Service Category Description

Core Service Category

Health Insurance Premium and Cost Sharing Assistance (HIPCSA) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services (OAHS), and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA Ryan White Program funds for health insurance premium and cost sharing assistance (not standalone dental insurance assistance), a HRSA Ryan White Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV Outpatient/Ambulatory Health Services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV OAHS.

To use HRSA Ryan White Program funds for standalone dental insurance premium assistance, a HRSA Ryan White Program recipient must implement a methodology that incorporates the following requirement:

- HRSA Ryan White Program recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate and allocate funding to HIA only when determined to be cost effective.

Program Guidance

Traditionally, HRSA Ryan White Parts A and B Program recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA Ryan White Part C or Part D

Program recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

Services

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes out-of-pocket costs such as premium payments, co-payments, coinsurance, and deductibles.

The cost of insurance plans must be lower than the cost of providing health services through grant-supported direct delivery (be "cost-effective"), including costs for participation in the Texas AIDS Drug Assistance Program (ADAP).

HIPCSA may be extended for job or employer-related health insurance coverage and plans on the individual and group market, including plans available through the federal Health Insurance Marketplace (Marketplace). HIPCSA funds may also be used towards premiums and out-of-pocket payments on Medicare plans and supplemental insurance policies, if the primary purpose of the supplemental policy is to assist with HIV-related outpatient care.

Funds may be used for:

- Purchasing health insurance (both job or employer-related plans and plans on the individual and group market) that provides comprehensive primary care and pharmacy benefits for clients that provide a full range of HIV medications;
- Standalone dental insurance premiums when cost effective and/or cost sharing assistance when provided in compliance with requirements described in HRSA Policy Clarification Notice (PCN) 16-02 (PDF), including the FAQ;
- Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV), deductibles, and co-insurance for medical and dental plans on behalf of the client;
- Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs; and/or
- Certain tax liabilities.

Limitations

HIPCSA must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.

Per HRSA/DSHS directive, CareLink is not an allowable service under HIPCSA.

For clients enrolled after 9/1/17 and all new or returning HIPCSA clients, the annual cap for Health Insurance is $12,343.05 per calendar year and for stand-alone Oral Health Insurance is

$2,500.00[7] (e.g. 1: a client is allowed a grand total of $12,343.05 for services across Ryan White Part A, Part B, Part D, **and** Operation BRAVE; not $12,343.05 per grant. e.g. 2: a client does **not** get $12,343.05 for Part A **and** $12,343.05 for Part D). This includes monthly premiums, deductibles, co-pays, and co-insurance. There is no cap for HIPCSA clients who have been continuously enrolled in HIPCSA services since 09/01/2017 or earlier.

HIPCSA cannot be in the form of direct cash payments to clients.

HIPCSA excludes plans that do not cover HIV-treatment drugs; specifically, the plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services.

Any cost associated with liability risk pools cannot be funded by Ryan White.

Ryan White Program funds cannot be used to cover costs associated with Social Security.

HIPCSA funds may not be used to pay fines or tax obligations incurred by clients for not maintaining health insurance coverage required by the Affordable Care Act (ACA).

HIPCSA funds may not be used to make out-of-pocket payments for inpatient hospitalization and emergency department care.

HIPCSA funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units	
Outpatient / Ambulatory Medical • Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Ambulatory/Outpatient Medical Care	Per payment
	Dermatology	Per payment
	Infectious Disease	Per payment
	Neurology	Per payment
	Ob/Gyn	Per payment
	Oncology	Per payment
	Ophthalmology	Per payment
	Other Specialty	Per payment
	Radiology	Per payment
	Laboratory - Service	Per payment
	CD-4 T-Cell Count	Per payment
	Viral Load Test	Per payment

[7] CAP set by AA 4.11 Cost Effectiveness Policy

Insurance – Medical • Premium and deductible payments for a client's medical insurance with a private insurance provider. Do not report payments to public payers (e.g. Medicare/Medicaid) here.	Deductible Payment	Per payment
	Premium Payment	Per month
Oral Health Care • Co-payments for Oral Health Care when a client has private dental insurance.	Routine Treatment	Per payment
	Prophylaxis	Per payment
	Specialty	Per payment
Insurance – Oral Health Care • Premium and deductible payments to a private insurer for dental insurance.	Deductible Payment	Per payment
	Premium Payment	Per month
AIDS Pharmaceutical Assistance (Local) (not Medicare, Medicaid or Part D) • Co-payments for a client's medications when a client has drug coverage from a private insurer.	Co-Payment	Per prescription
Insurance - Prescription Drugs (not Medicare, Medicaid or Part D) • Premium and deductible payments for prescription drug benefits with a private insurer.	Deductible Payment	Per payment
	Premium Payment	Per month
Medicare/Medicaid Supplement • Premium, deductible or co-payments to Medicare/Medicaid.	Deductible Payment	Per payment
	Co-Payment	Per payment
	Premium Payment	Per month
	Deductible Payment – Part D	Per payment
	Co-Payment – Part D	Per payment
	Premium Payment – Part D	Per month
Other Health Insurance • Premium, deductible or co-payments to other health insurers.	Deductible Payment	Per payment
	Co-Payment	Per payment
	Premium Payment	Per month

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Health Insurance Plans	
Standards Requirement	Monitoring Indicators
The agency must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core anti- retro viral treatment (ART) from the HHS treatment guidelines along with Outpatient/ Ambulatory Health Services (OAHS) and Oral Health Care that meet the requirements of the ACA law for essential health benefits. This must be documented in the client's primary record.	Indicator 1: Percentage of clients with documented evidence that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications. Indicator 2: Percentage of clients with documented evidence that the insurance plan purchased provides comprehensive oral healthcare services.

Section B: Co-payments, Premiums, Deductibles, and Co-insurance	
Standards Requirement	Monitoring Indicators
Otherwise, eligible clients with job or employer-based insurance coverage, Qualified Health Plans (QHP), or Medicaid plans, can be provided assistance to offset any cost-sharing programs may impose. Clients must be educated on the cost and their responsibilities to maintaining medical adherence. Education must be provided to clients specific to what is reasonably expected to be paid for by an eligible plan and what RWHAP can assist with to ensure healthcare coverage is maintained. Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.	Indicator 3: Percentage of clients with documented evidence of education provided regarding reasonable expectations of assistance available through RWHAP Health Insurance to assist with healthcare coverage as indicated in the client's primary record. Indicator 4: Percentage of clients with documented evidence of insurance payments made to the vendor within five (5) business days of the approved request.

Section C: Cost Sharing Education	
Standards Requirement	Monitoring Indicators
Education is provided to clients, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. It must be evidenced in the client's primary record that the individual must receive a premium tax credit and enroll in a silver level plan offered in the Marketplace. Clients who are not eligible for cost-sharing reductions (those under 100% FPL in Texas; those with incomes above 400% FPL; clients who have minimum essential coverage other than individual market coverage and choose to purchase in the marketplace; and those who are ineligible to purchase insurance through the marketplace) are provided education on cost-effective resources available for the client's health care needs.	Indicator 5: Percentage of clients with documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the client's primary record.

Section D: Premium Tax Credits Education	
Standards Requirement	Monitoring Indicators
Agencies have documented evidence in the client's primary record of the enrollment in a QHP in the Marketplace, as applicable to the individual (clients that are between 100-400% FPL without access to minimum essential coverage). Education provided to the client regarding tax credits and the requirement to file income tax returns must be documented in the client's primary record. Clients must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline.	Indicator 6: Percentage of clients with documented evidence of education provided regarding premium tax credits as indicated in the client's primary record.

Section E: Prescription Eyewear	
Standards Requirement	Monitoring Indicators
Agency must keep documentation of a physician's written statement stating that the eye condition is related to the client's HIV when HIPCSA funds are used to cover co-pays for prescription eyewear.	Indicator 7: Percentage of client files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the client's HIV as indicated in the client's primary record.

Section F: Medical Visits	
Standards Requirement	Monitoring Indicators
Clients accessing health insurance premium and cost sharing assistance services are adherent with their HIV medical or dental care and have documented evidence of attendance of HIV medical or dental appointments in the client's primary record. *Note*: For clients who use HIPCSA to enable their use of medical or dental care outside of the RW system: HIPCSA providers are required to maintain documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months.	Indicator 8: Percentage of clients who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (HRSA HAB Measure)

Section G: Viral Suppression	
Standards Requirement	Monitoring Indicators
Clients receiving Health Insurance Premium and Cost-Sharing Assistance services have evidence of viral suppression as documented in viral load testing.	Indicator 9: Percentage of clients with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. (HRSA HAB Measure)

References

42 U.S. Code (USC) 1395w–102(b)(4)(C)(iii)

PHS Act § 2604(c)(3)(F)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance Revised 08/30/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act Revised 04/03/2015 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act Frequently Asked Questions June 2015 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Advanced Premium Tax Credits Under the Affordable Care Act 07/14/2014 Federal Register (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 13-04: Clarifications Regarding Clients Eligible for Private
Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program Revised 09/13/2013 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Program Letters: Using Ryan White HIV/AIDS Program Funds to Support Standalone Dental Insurance 12/05/2016 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Program Letters: ADAP/TrOOP 11/23/2010 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

University Health Ryan White Program Administration Policy: 4.07 Health Insurance Policy for the Part A & MAI Program

University Health Ryan White Program Administration Policy: 4.11 Cost Effectiveness Policy for the Part A & MAI Program

Medical Case Management (MCM), including Treatment Adherence Services

HRSA Service Category Description

Core Service Category

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

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

Key activities include:

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

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

Program Guidance

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

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

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

<table>
<tr><th>MCM Examples</th><th>NMCM Examples</th><th>RHSS Examples (No MCM/NMCM)</th></tr>
<tr><td>Requires assistance with achieving or maintaining viral suppression</td><td>Advice and assistance in obtaining medical, social, community, legal, financial and other needed services</td><td>Clients who do not need case management but require a voucher for a service</td></tr>
<tr><td>Follow-up of Medical Treatments: includes either accompanying client to medical appointments</td><td rowspan="3">Providing specific services such as housing assistance or transportation are not case management; but identifying and arranging to have that assistance provided is case management</td><td>Needs help with transportation for medical appointments</td></tr>
<tr><td rowspan="2">Treatment Adherence: the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments</td><td>Client requires general financial assistance</td></tr>
<tr><td>Client needs referrals for health services</td></tr>
</table>

Services

Staff providing MCM services act as part of a multidisciplinary medical care team, with a specific role of assisting clients in following their medical treatment plan and assisting in the coordination and follow-up of the client's medical care between multiple providers. The goals of this service are:

1. the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the staff providing Medical Case Management services,
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 client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system, and
3. Client specific advocacy and/or review of utilization of services provided and needed by client.

Core components of Medical Case Management 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 client to medical appointments, calling, emailing, texting or writing letters to clients with respect to

various treatments to ensure appointments were kept or rescheduled as needed. Additionally, follow-up also includes ensuring clients 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, HIV treatments.to achieve and maintain viral suppression.

Limitations

Medical Case Management is a service based on need and is not appropriate or necessary for every client accessing services. Medical Case Management is designed to only serve individuals who have complex needs related to their ability to access and maintain HIV medical care. *Medical Case Management should not be used as the only access point for medical care and other agency services*. Clients who do not need Medical Case Management services to access and maintain medical care should not be enrolled in Medical Case Management services. When clients are able to maintain their medical care, clients should be graduated. Clients with ongoing existing need for Treatment Adherence support due to mental illness or other documented behavioral disorders meet the criteria for Medical Case Management services.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Medical Case Management	Per 15 minutes

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Initial Comprehensive Assessment	
Standards Requirement	Monitoring Indicators
Initial Comprehensive Assessment must be completed within 30 calendar days of the first appointment to access MCM services and includes at a minimum: 1. Client health history, health status and health-related needs, including but not limited to: • HIV disease progression • Tuberculosis • Hepatitis • STI history and/or history of screening • Other medical conditions • OB/GYN as appropriate, including pregnancy status • Routine health maintenance (ex. Well women exams, pap smears) • Medications and adherence, including allergies to medications • Complementary therapy • Current health care providers; • engagement in and barriers to care • Oral health care • Vision care • Home health care and community-based services • Substance Use (validated and reliable substance use disorder screening tool must be used. See SAMISS.) • Mental Health (validated and reliable mental health screening tool must be used) • Medical Nutritional Therapy • Clinical trials • Family Violence • Sexual health assessment and risk reduction counseling 2. Additional information • Client strengths and resources • Other agencies that serve client and household • Progress note of assessment session(s) • Supervisor signature and date, signifying review and approval, for staff providing medical case management staff during their probationary period.	Indicator 1: Percentage of clients that have a completed initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services and includes all required documentation in the primary client record system. Indicator 2: Percentage of clients that received at least one face-to-face (in person or telehealth) meeting with staff providing MCM services that conducted the initial comprehensive assessment. Indicator 3: Percentage of clients with documented education on basic HIV information as needed (newly diagnosed, return to care), including explanation of viral load and viral suppression. Indicator 4: Percentage of clients with documented evidence of sexual health literacy and education provided on harm reduction, as needed.

Section B: Medical Case Management Acuity Level and Client Contact	
Standards Requirement	Monitoring Indicators
Clients who access MCM services have a documented acuity level using an approved acuity scoring tool with the comprehensive assessment. Each interaction with a client has the potential to change acuity scores in specific categories. Any changes in a client's acuity should be documented appropriately. Acuity and frequency of contact is documented in the primary client record system. *NOTE*: *The team providing MCM services has the discretion to (1) determine priority need clients that should be enrolled in MCM services and (2) clients who have low acuity scores but are high need and/or high-risk clients for falling out of care. Clear and detailed documentation must be present in the client's primary record.*	Indicator 5: Percentage of clients who have a completed acuity level documented using an approved acuity scale with the comprehensive assessment and documented in the primary client record. Indicator 6: Percentage of clients that have documented evidence of review of acuity, minimum every three (3) months, to ensure acuity is still appropriate level for the client's needs in the primary client record. Indicator 7: Percentage of clients with a documented decreased acuity during the measurement year in the primary client record. Indicator 8: Percentage of clients with documented evidence of acuity and frequency of contact by staff matches acuity level in the primary client record. Indicator 9: Percentage of clients with documentation that the initial assessment of service needs activity is being carried out for clients as necessary in the primary client record.

Section C: Care Planning	
Standards Requirement	Monitoring Indicators

The client and the staff providing MCM services will actively work together to develop and implement the medical case management care plan. This is not a nursing care plan. Care plans include at a minimum:
• Problem Statement (Need)
• Goal(s) – suggest no more than three goals
• Intervention
  ○ Task(s)
  ○ Referral(s)
  ○ Service Deliveries
• Individuals responsible for the activity (staff providing MCM services, client, other team member, family)
• Anticipated time for each task
 	
The care plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals, at a minimum, every six (6)
	Indicator 10: Percentage of clients who had a medical case management care plan developed in the measurement year. (HRSA HAB Measure)
	
	Indicator 11: Percentage of clients who had a medical case management care plan updated two or more times in the measurement year. (HRSA HAB Measure)
	
	Indicator 12: Percentage of client records with documented issues noted in the care plans that have ongoing case notes that match the stated need and the progress towards meeting the goal identified, as indicated in the primary client record.
	
	Indicator 13: Percentage of clients with documentation that the development of a comprehensive, individualized care plan activity is being carried out for clients as necessary in the primary client record.

months. Tasks, referrals and services should be updated as they are identified or completed – not at set intervals.	Indicator 14: Percentage of clients with documentation that the coordination of services required to implement the plan activity is being carried out for clients as necessary in the primary client record. Indicator 15: Percentage of clients with documentation in client record of case management services and encounter types of services provided. Indicator 16: Percentage of clients with documentation in client record of case management services and encounter types of encounters/communication. Indicator 17: Percentage of clients with documentation in client record of case management services and encounters duration and frequency of the encounters. Indicator 18: Percentage of clients with documentation in client records of client-specific advocacy. Indicator 19: Percentage of clients with documentation that the continuous client monitoring to assess the efficacy of the plan activity is being carried out for clients as necessary in the primary client record. Indicator 20: Percentage of clients with documentation that the periodic re-evaluation and adaptation of the plan at least every six months during the enrollment of the client activity is being carried out for clients as necessary in the primary client record. Indicator 21: Percentage of clients with documentation in client records of ongoing assessment of the client's and other key family members' needs and personal support systems in the primary client record.

Section D: Viral Suppression/Treatment Adherence	
Standards Requirement	Monitoring Indicators
An assessment of treatment adherence support needs and client education should begin as soon as client's access MCM services and should continue as long as a client continues to access MCM services. Medical Case Management services should involve an individually tailored adherence intervention program, *and staff providing medical case management services should reinforce treatment adherence at every contact whether it is during face-to-face contact or telephone contact.* The following criteria are recommendations that can help staff providing medical case management services and clients examine the client's current and historical adherence to both medical care and treatment regimens: • *Medication and Treatment Adherence:* Relates to current level of adherence to ARV medication regimen and client ability to take medications as prescribed. Staff providing MCM services will use any available treatment adherence tool to promote adherence for clients who demonstrate challenges with adherence (e.g., not taking ARV medications as prescribed, missing appointments, etc.) • *Appointments:* Relates to current level of completion of appointments for core medical services and understanding of the importance of regular attendance at medical and non- medical appointments in order to achieve positive health outcomes. • *ARV Medication Side Effects:* Relates to potential adverse side effects associated with ARV treatment and the impact on functioning and adherence. Staff providing MCM services will discuss side effects of medications as challenges and barriers to treatment adherence. • *Knowledge of HIV Medications:* Relates to client understanding of prescribed ARV regimen, the role of medications in achieving positive health outcomes and techniques to manage side effects (e.g., providing education to client on importance and relation of adherence to ARV to achieve and maintain viral suppression, thus preventing onward transmission). • *Treatment Support:* Relates to client relationship with family, friends, and/or community support systems, which may either promote or hinder client adherence to treatment protocols.	Indicator 22: Percentage of clients with documented education about the goals of HIV treatment. Indicator 23: Percentage of clients who were provided treatment counseling as indicated for those clients who demonstrate challenges with adherence (not taking their medications as prescribed, missing doses) with education documented in the primary client record system. Indicator 24: Percentage of clients who were provided education on treatment adherence as determined necessary for clients who demonstrate challenges with adherence and education is documented in the primary client record system. Indicator 25: Percentage of clients who had a medical visit in the last 6 months of the measurement year (that is documented in the medical case management record). (HRSA HAB measure) Indicator 26: Percentage of clients who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (HRSA HAB Measure) Indicator 27: Percentage of clients with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. (HRSA HAB Measure)

Section E: Referral and Follow-up	
Standards Requirement	Monitoring Indicators
Staff providing MCM services will work with the client to determine barriers to referrals and facilitate access to referrals. Staff providing MCM services will ensure that clients are accessing needed referrals and services and will identify and resolve any barriers clients may have in following through with their Care Plan. When clients are referred for services elsewhere, case notes include documentation of the completed referral with outcome of the referral in the primary client record system.	Indicator 28: Percentage of clients with documented referrals initiated immediately with client agreed participation upon identification of client needs. Indicator 29: Percentage of clients with documented referrals declined by the client in the primary client record system. Indicator 30: Percentage of clients with referrals that have documentation of follow up to the referral including appointment attended and the result of the referral. Indicator 31: Percentage of clients with documentation in client record of client-centered services that link clients with healthcare, psychosocial, and other services and assist them in accessing other public and private programs for which they may be eligible. Indicator 32: Percentage of clients with documentation in client record of coordination and follow up of medical treatments.

Section F: Case Closure/Graduation	
Standards Requirement	Monitoring Indicators
Clients who are no longer engaged in active medical case management services should have their cases closed with a case closure summary documented based on the criteria and protocol outlined below. Common reasons for case closure, as applicable, include: • Client is referred to another medical case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client is/will be incarcerated for more than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations, per agency's policy and/or procedures • Client's death Graduation criteria:	Indicator 33: Percentage of clients with closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary) in the primary client record system. Indicator 34: Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). Indicator 35: Percentage of clients that are notified (through face-to-face meeting, telephone conversation, or letter) of plans for case closure of the client's file from medical case management services. Indicator 36: Percentage of clients with written documentation explaining the reason(s) for case closure/graduation and the process to be followed if client elects to appeal the case closure/graduation from service.

• Client completed medical case management goals • Client is no longer in need of medical case management services (e.g. client is capable of resolving needs independent of medical case management assistance) Client is considered to be "out of care" if three (3) attempts to contact client (via phone, e-mail and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Case closure proceedings should be initiated by agency 30 days following the 3rd attempt. *Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. *Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electric dissemination of protected health information (PHI).*	Indicator 37: Percentage of clients that are provided with contact information and process for reestablishment as documented in primary client record system.

References

PHS Act § 2604(c)(3)(M)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 18-02: The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved 2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Medical Nutrition Therapy (MNT)

HRSA Service Category Description

Core Service Category

Medical Nutrition Therapy (MNT) includes:

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

These services can be provided in individual and/or group settings and outside of HIV Outpatient/ Ambulatory Health Services (OAHS).

Program Guidance

All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the Registered Dietitian (RD) or other licensed nutrition professional.

Services not provided by a registered/licensed dietitian should be considered Psychosocial Support Services under the Ryan White Program.

In the State of Texas, the only allowable nutrition professional recognized for Medical Nutrition Therapy service category is a licensed Registered Dietitian.

Services

The application of MNT as a part of the Nutrition Care Process is an integral component of the medical treatment for management of specific disease states and conditions and should be the initial step in the management of these situations. Efforts to optimize nutritional status through individualized medical nutrition therapy, assurance of food and nutrition security, and nutrition education are essential to the total system of health care available to people living with HIV through the continuum of care.

MNT is individualized dietary instruction that incorporates diet therapy counseling for a nutrition-related problem. This level of specialized instruction is above basic nutrition counseling and includes an individualized dietary assessment performed by a RD.

Services include providing nutritional supplements and food provisions based on the medical care provider's recommendation:

- Nutritional supplements include medical nutritional formula, vitamins, and herbs;
- Food provisions consist of recommending significant change in daily food intake based on a deficiency, which may directly affect HIV/co-morbidities.

Limitations

Services must be provided by a Registered Dietitian or other licensed nutrition professional pursuant to a medical provider's written referral. Nutritional services and nutritional supplements not provided by an RD shall be considered a support service under Psychosocial Support Services under the RWHAP.

Food provisions and nutritional supplements **not** provided pursuant to a physician's recommendation *and* a nutritional plan developed by an RD also shall be considered a support service under Food Bank/Home-Delivered Meals.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Medical Nutrition Therapy - Counseling	Per 15 minutes
Medical Nutrition Therapy - Supplements (Supplements recommended by someone other than a licensed dietitian should be funded and recorded under Food Pantry/Voucher with Nutritional Supplements.)	Per transaction

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Medical Nutrition Therapy Assessment	
Standards Requirement	Monitoring Indicators
An initial MNT assessment will be conducted by an RD pursuant to a medical provider's referral. MNT provider will contact the patient for the initial nutritional assessment within five (5) business days of the referral. The initial MNT assessment must be completed within ten (10) business days of the initial appointment with the RD.	Indicator 1: Percentage of clients with documentation of a referral by a licensed medical provider in the cline's primary record. Indicator 2: Percentage of clients with a documented completed MNT assessment conducted within 10 business days of initial appointment by the RD in the client's primary record.

MNT provider obtains and documents HIV primary medical care provider contact information for each patient. MNT services must be provided in consultation with the medical care provider for medical coordination. MNT provider collects and documents assessment history information with updates as medically appropriate prior to providing care. This information must be based on the Academy of Nutrition & Dietetics (AND) Evidence Based Guidelines that include, but not be limited to: • *Anthropometrics*: height and weight; pre-illness usual weight and goal weight; and body muscle and fat. • *Clinical data*: medical history. • *Dietary data*: individual's food preferences including ethnic and cultural food preferences and practices; information about allergies, food intolerances, and food avoidances; exercise frequency; food security. • *Biochemical*: lab data from the primary medical care provider.	

Section B: Nutrition Plan	
Standards Requirement	Monitoring Indicators
A nutritional plan will be developed appropriate for the client's health status, financial status, and individual preference. A Nutritional Plan is completed within ten (10) business days of Nutrition Assessment and includes, but is not limited to: • Nutritional diagnosis • Recommended services and course of medical nutrition therapy to be provided, to include types and amounts of nutritional supplements and food provisions • Date service is to be initiated • Planned number and frequency of sessions • Measurable goal • where food is provided to a client under this service category The plan will be signed by the RD developing the plan. The Nutrition Plan will be updated as necessary, but no less than at least twice per year, and will be shared with the client, the client's primary care provider, and other authorized personnel involved in the client's care.	Indicator 3: Percentage of clients with documentation of a detailed nutritional treatment plan for each eligible client in the client's primary record. Indicator 4: Percentage of clients with documentation of the required content in the nutritional plan to include the diagnosed condition for which medical nutrition therapy is needed. Indicator 5: Percentage of clients with documentation of the required content in the nutritional plan to include recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food. Indicator 6: Percentage of clients with documentation of the required content in the nutritional plan to include date the service is to be initiated. Indicator 7: Percentage of clients with documentation of the required content in the nutritional plan to include planned number and frequency of sessions.

	Indicator 8: Percentage of clients with documentation of the required content in the nutritional plan to include the signature of the RD who developed the plan. Indicator 9: Percentage of clients with documentation of the required content in the nutritional plan to include where food is provided to a client under this service category. Indicator 10: Percentage of clients that have an updated nutrition plan at least twice per year as documented in the client's primary record.

Section C: Services Provided	
Standards Requirement	Monitoring Indicators
According to the American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care nutritional services will be provided. The frequency of contact with the RD will be based on the level of care needed per the initial assessment. Nutritional intervention will focus on set standards of medical nutrition therapy that targets measurable goals, recommended services, and course of medical nutrition therapy as outlined in the Nutrition Plan. Emerging problems such as lipodystrophy syndrome will be addressed and added to the nutrition plan as needed. Services will be documented in the patient's chart and signed by the RD providing care at each visit.	Indicator 11: Percentage of clients that have documentation in the client's primary record of frequency of contact with the RD to review the nutritional plan and goals as indicated in the initial assessment. Indicator 12: Percentage of clients with RD notes documented in the client's primary record of nutritional interventions and recommendations. Indicator 13: Percentage of clients show improvement in issues identified in the initial assessment as documented by the RD in the client's primary record. Indicator 14: Percentage of clients with documentation that services provided to include date of reassessment. Indicator 15: Percentage of clients with documentation of services provided with the signature of each RD who rendered service and the date of service.

Section D: Provision of Nutritional Supplements and Food Provisions	
Standards Requirement	Monitoring Indicators
Nutritional supplements and food provisions deemed medically necessary may be provided per written orders from a prescribing physician. Upon receipt of the written referral by the primary medical care provider to the RD, clients may receive up to a 90-day supply of nutritional supplements at one time in accordance with their MNT developed nutritional plan.	Indicator 16: Percentage of clients that are prescribed nutritional supplements in accordance with the nutritional plan developed by the RD have documented evidence of nutritional supplements and food provided, quantity, and dates in the client's primary record.

Nutritional supplements and food provisions must be outlined in the written nutrition plan by the RD. The written nutritional plan must be communicated with the primary HIV prescribing provider.	

Section E: Nutrition Education	
Standards Requirement	Monitoring Indicators
Patient nutritional health education will be offered to each patient a minimum of once a year that includes, but is not limited to: • Benefits of good nutrition • Special dietary needs of people with HIV/AIDS • Supplementation • Coping with complications	Indicator 17: Percentage of clients with documented evidence of nutritional health education provided in the client's primary record.

Section F: Referrals	
Standards Requirement	Monitoring Indicators
At a minimum, patients will receive referrals to specialized health care providers/services as needed to augment MNT that includes, but is not limited to: • Other medical professionals such as social workers, mental health providers, or case managers • Community resources such as food pantries; SNAP/food stamps; Women, Infants and Children Supplemental Food Program (WIC), etc. • Nutrition classes • Exercise facilities • Other education and economic resource groups MNT provider will document referral and outcome in the client's record.	Indicator 18: Percentage of clients that had documentation of referrals to other services as indicated in the client's primary record. Indicator 19: Percentage of clients have follow up documentation to the referral offered in the client's primary record.

Section G: Discharge	
Standards Requirement	Monitoring Indicators
An individual is deemed no longer to need MNT if one or more of these criteria is met: • Patient's medical condition improves, and MNT services are no longer necessary • Patient deceased • Patient moves out of the service area Date of discharge, reason, and any recommendations for follow up shall be documented in the patient's record and the primary medical provider notified.	Indicator 20: Percentage of clients with documentation of discharge noted in the client's primary record as applicable. Indicator 21: Percentage of clients with documentation with the date of discharge in the client's primary record as applicable. Indicator 22: Percentage of clients with documentation of any recommendations for follow up in the client's primary record as applicable.

References

PHS Act § 2604(c)(3)(H)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Agency for Healthcare Research and Quality. HIV/AIDS evidence-based nutrition practice guideline

Living well with HIV/AIDS. A manual on nutritional care and support for people living with HIV/AIDS

The American Dietetic Association. Medical Nutrition Therapy Across the Continuum of Care, Second Edition, October, 1998.

The American Dietetic Association. HIV/AIDS evidence-based nutrition practice guideline. Chicago (IL): American Dietetic Association; December, 2010. (PDF)

Medical Transportation (MT)

HRSA Service Category Description

Support Service Category

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

Program Guidance

Medical Transportation may be provided through:

- Contracts with providers of transportation services, including ride share service providers;
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations [DOD]) provide further guidance on this subject;
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle from the Administrative Agency (AA), DSHS, and HRSA HIV/AIDS Bureau (HAB) as applicable;
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); and/or
- Voucher or token systems.

Services

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 clients receive Ryan White defined core or support services, and/or medical and health-related care services, including clinical trials, essential to their well-being.

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 State of Texas vehicle registration.

Medical Transportation must be reported as a support service in all cases, regardless of whether the client is transported to a core or support service.

Limitations

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients;
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle; and

- Any other costs associated with a privately owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Medical Transportation cannot be used to transport a client in need of emergency medical care.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Medical Transportation Services	Per one way trip

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Client Education Regarding Services Available and Limitations	
Standards Requirement	Monitoring Indicators
Clients are provided with information on transportation services and instructions on how to access the services. • General transportation service hours should correspond with the business hours of local core medical and support services that client's access. • Clients must be able to confirm their transportation arrangements to core or support service appointments at least two business days in advance for medical transportation services offered via van, ride share, or volunteer-operated vehicles. This does not apply to transportation solutions relying on fare media (e.g., bus passes, bus tokens, taxi vouchers). The agency provides clients with information on transportation limitations, clients' responsibilities for accessing the receiving transportation, and the agency's responsibilities for providing transportation.	Indicator 1: Percentage of clients that have documented evidence of education provided regarding services available and limitations in the primary client record. Indicator 2: Percentage of clients that have documentation that medical transportation services are used only to enable an eligible individual to access HIV-related health and support services.

Section B: Screening for Other Transportation Resources	
Standards Requirement	Monitoring Indicators
Client shall be screened for other transportation resources (e.g., Medicaid-eligible clients using DSHS Medicaid transportation program). Sub-recipients must enforce Payor of last resort requirements for transportation. Clients eligible for State of Texas Medicaid Transportation (MTP) cannot be billed to RW unless there is documentation in the client file that the State of Texas MTP program cannot meet the need for the needed transportation event (e.g., not available for the date and time of the scheduled OAHS appointment).	Indicator 3: Percentage of clients that have documented evidence of screening completed of other resources for transportation services in the primary client record.

Section C: Client Signed Statement	
Standards Requirement	Monitoring Indicators
A signed statement from the client consenting to transportation services and agreeing to safe and proper conduct in any vehicle is documented in the client's primary record. This statement is to include the consequences of violating the agreement such as removal, suspension, and/or possible termination of transportation services (not applicable to fare media-supported services such as bus passes or tokens).	Indicator 4: Percentage of clients that have documented evidence of a signed statement agreeing to safe and proper conduct in the primary client record.

Section D: Use of Agency Vehicles	
Standards Requirement	Monitoring Indicators
When Agency Conveyance is used for medical transportation, clients and agencies are made aware of problems immediately (e.g. vehicle breakdown) and notification documented. The Agency shall ensure that the transportation program has the capability to provide alternate transportation (e.g. taxi, ride share) to eligible clients in, at a minimum, the following situations: • Service is unavailable due to primary transportation vehicle breakdown, driver unavailability, or inclement weather; • Client's non-emergency medical need requires immediate transport; • Scheduling conflicts; and/or • Other locally determined events where missing an appointment may impose significant hardship upon a client (e.g. missing a Social Security Disability hearing).	Indicator 5: Percentage of clients that have documented evidence, as applicable, of issue reported to the client and other arrangements are made to accommodate the client need in the primary client record.

Section E: Documentation of "No Shows"	
Standards Requirement	Monitoring Indicators
Client "no shows" are documented in either a transportation log and/or the client's primary record where an agency's conveyance or contracted transportation service provider (such as taxi services, ride share providers, etc.) is transporting clients from their home to necessary core and/or support services. Core medical and support service providers are promptly notified by the Medical Transportation agency regarding client "no shows."	Indicator 6: Percentage of clients that have documented evidence where a client does not show for an agency conveyance or contracted service scheduled appointment.

Section F: Access to Care	
Standards Requirement	Monitoring Indicators
Clients accessing Medical Transportation services have evidence of attendance to their core and/or support services where Medical Transportation services were required to access and retain a client in care.	Indicator 7: Percentage of clients who have documentation of evidence of access and retention in medical care, other core services, and/or support services in the primary client record.

References

American with Disabilities Act (ADA)

PHS Act § 2604(d)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

State of Texas Transportation Code Title 7, Subtitle C, Chapter 545. Operation and movement of Vehicles

Texas Department of Public Safety. Classes of Drivers Licenses

Mental Health (MH) Services

HRSA Service Category Description

Core Service Category

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

Services

Mental health counseling services include outpatient mental health therapy and counseling 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
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription and monitoring
- Psychotropic medication management
- Drop-in psychotherapy groups
- Emergency/crisis intervention

All mental health interventions must be based on proven clinical methods and in accordance with legal, licensing, 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).

Limitations

Mental Health Services *are allowable only for people living with HIV* who are eligible for HRSA Ryan White Program services.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Mental Health Services – Individual	Per visit
Mental Health Services – Group	Per visit
Mental Health Services – Psychiatric Evaluation	Per visit
Mental Health Services – Psychiatric Follow-up	Per visit

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Client Orientation	
Standards Requirement	**Monitoring Indicators**
Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation includes written or verbal information provided to the client on the following: • Services available • Clinic hours and procedures for after-hours emergency and non-life-threatening urgent situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process • Behavior that is considered unacceptable and the agency's progressive action for suspension of services, see DSHS Policies 530.003 and 530.002	Indicator 1: Percentage of new clients with documented evidence of orientation to services available in the client's primary record.

Section B: Mental Health Assessment	
Standards Requirement	Monitoring Indicators

All clients referred to the program will receive a mental health assessment by licensed mental health professionals. A mental health assessment should be completed no later than the third counseling session and should include, at a minimum, the following as guided by licensure requirements:
• Presenting problems
• Completed mental status evaluation (including appearance and behavior, self-attitude, speech, psychomotor activity, mood, insight, judgment, suicidal ideation, homicidal ideation, perceptual disturbances, obsessions/compulsions, phobias, panic attacks)
• Cognitive assessment (level of consciousness, orientation, memory, and language)
• Current risk of danger to self and others
• Living situation
• Social support and family relationships, including client strengths/challenges, coping mechanisms and self-help strategies
• Medical history
• Current medications
• Substance use history
• Psychosocial history to include:
  ○ Education and employment history, including military service
  ○ Sexual and relationship history and status
  ○ Physical, emotional, and/or sexual abuse history
  ○ Domestic violence assessment
  ○ Trauma assessment
  ○ Legal history
  ○ Leisure and recreational activities
 	
Clients are assessed for care coordination needs and referrals are made to case management programs, as appropriate. If pressing mental health needs emerge during the mental health assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client's primary record.
	Indicator 2: Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record.

Section C: Treatment Plan	
Standards Requirement	Monitoring Indicators
All eligible client files should have documented evidence of a detailed treatment plan and documentation of services provided within the client's primary record. A treatment plan shall be completed within 30 days from the Mental Health Assessment. The treatment plan should include: • Diagnosed mental health issue • Goals and objectives • Treatment type (individual, group) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date (estimated) • Any recommendations for follow up Treatment, as clinically appropriate, should include counseling regarding: • Risk reduction and health promotion • Substance use disorder • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals The treatment plan must be signed by the mental health professional rendering service and developed in conjunction with the client. Electronic signatures are acceptable. Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated.	Indicator 3: Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. Indicator 4: Percentage of clients with documentation of the existence of a detailed treatment plan for each eligible client that includes the diagnosed mental illness or condition. Indicator 5: Percentage of clients with documentation of the existence of a detailed treatment plan for each eligible client that includes the treatment modality (group or individual). Indicator 6: Percentage of clients with documentation of the existence of a detailed treatment plan for each eligible client that includes start date for mental health services. Indicator 7: Percentage of clients with documentation of the existence of a detailed treatment plan for each eligible client that includes recommended number of sessions. Indicator 8: Percentage of clients with documentation of service provided to ensure that services provided are consistent with the treatment plan. Indicator 9: Percentage of clients with documentation of the existence of a detailed treatment plan for each eligible client that includes any recommendations for follow up. Indicator 10: Percentage of clients with documentation of the existence of a detailed treatment plan for each eligible client that includes date for reassessment. Indicator 11: Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record. Indicator 12: Percentage of clients with documentation of the existence of a detailed treatment plan for each eligible client that includes projected treatment end date. Indicator 13: Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record.

Section D: Psychiatric Referral	
Standards Requirement	Monitoring Indicators
Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	Indicator 14: Percentage of clients with documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.

Section E: Psychotropic Medication Management	
Standards Requirement	Monitoring Indicators
Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. Mental health providers with prescriptive authority will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part1, Chapter 415, Subchapter A, Rule 415.10.	Indicator 15: Percentage of clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. Indicator 16: Percentage of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.

Section F: Provision of Services	
Standards Requirement	Monitoring Indicators
Services will be provided according to the individual's treatment plan and documented in the client's primary record. Progress notes are completed according to the agency's standardized format for each session and will include: • Client name • Session date • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Counselor signature and authentication (credentials). In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the client to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s).	Indicator 17: Percentage of clients with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.

Section G: Coordination of Care	
Standards Requirement	Monitoring Indicators
Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	Indicator 18: Percentage of clients who have documented evidence in the client's primary record of care coordination, as permissible, of shared mental health treatment adherence with the client's prescribing provider.

Section H: Referrals	
Standards Requirement	Monitoring Indicators
As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis	Indicator 19: Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

Section I: Discharge Planning	
Standards Requirement	Monitoring Indicators
Discharge planning will be done with each client when treatment goals are met or when client has discontinued therapy either by initiating closure or as evidenced by non-attendance of scheduled appointments, as applicable. Documentation for discharge planning will include, as applicable: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements	Indicator 20: Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record. Indicator 21: Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.

References

PHS Act § 2604(c)(3)(K)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS , Washington, DC, 2001. (PDF)

American Psychiatric Association. Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS, Washington, DC, 2006. (PDF)

New York State Department of Health, Mental Health Standards of Care, Delivery of Care

Non-Medical Case Management (NMCM) Services

HRSA Service Category Description

Support Service Category

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

Key activities include:

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

Program Guidance

Activities provided under the *Non-Medical Case Management* service category have as their objective providing coordination, guidance, and assistance in *improving access* to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas *activities* provided under the *Medical Case Management* service category have as their objective *improving health care outcomes*.

MCM Examples	NMCM Examples	RHSS Examples (**No** MCM/NMCM)
Requires assistance with achieving or maintaining viral suppression	Advice and assistance in obtaining medical, social, community, legal, financial and other needed services	Clients who do not need case management but require a voucher for a service
Follow-up of Medical Treatments: includes either accompanying client to medical appointments	Providing specific services such as housing assistance or transportation are not case management; but identifying and arranging to have that assistance provided is case management	Needs help with transportation for medical appointments
Treatment Adherence: the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments		Client requires general financial assistance
		Client needs referrals for health services

Services

Non-Medical Case Management services provide guidance and assistance to clients to help them to access needed services (medical, social, community, legal, financial, and other needed services), but may not analyze the services to enhance their care toward improving their health outcomes.

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

Limitations

Non-Medical Case Management services do not involve coordination and follow up of medical treatments.

Non-Medical Case Management is a service based on need and is not appropriate or necessary for every client accessing services. Non-Medical Case Management is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). *Non-Medical Case Management should not be used as the only access point for medical care and other agency services*. Clients who do not need guidance and assistance in improving/gaining access to needed services should not be enrolled in NMCM services. When clients can maintain their care, clients should be graduated. Clients with ongoing existing needs due to impaired cognitive functioning, legal issues, or other documented concerns meet the criteria for NMCM services.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Non-Medical Case Management	Per 15 minutes

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Initial Assessment	
Standards Requirement	Monitoring Indicators
The Initial Assessment is required for clients who are enrolled in Non-Medical Case Management (N-MCM) services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer-standing access and/or barriers to medical and/or psychosocial needs. The 30 day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: 1. Client's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (e.g. food, shelter, education, medical, safety (Texas Department of Family Protective Services (TDFPS) Child Protective Services CPS/TDFPS Adult Protective Services (APS) referral as indicated) • Family violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, Social Security Disability Insurance (SSDI)/Supplemental Security Income (SSI) applications) • Linguistic services, including interpretation and translation needs • Activities of daily living	Indicator 1: Percentage of clients who that have a completed assessment within 30 calendar days of the first appointment to access NMCM services and includes all required documentation. Indicator 2: Percentage of clients that received at least one face-to-face (in person or telehealth) meeting with the NMCM staff that conducted the initial assessment. Indicator 3: Percentage of clients who have a documented initial assessment in the primary client record system.

• Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education 2. Additional information • Client strengths and resources • Other agencies that serve client and household • Brief narrative summary of assessment session(s)	

Section B: Care Planning	
Standards Requirement	Monitoring Indicators

The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum:
• Problem Statement (Need)
• Goal(s) – suggest no more than three goals
• Intervention
  ○ Task(s)
  ○ Assistance in accessing services (types of assistance)
  ○ Service Deliveries
• Individuals responsible for the activity (case management staff, client, other team member, family)
• Anticipated time for each task
• Client acknowledgment
 	
The care plan is updated with outcomes and revised or amended in response to changes in access to care and services at a minimum every six (6) months. Tasks, types of assistance in accessing services, and services should be updated as they are identified or completed – not at set intervals.
	Indicator 4: Percentage of clients who had a non-medical case management care plan developed in the measurement year.
	
	Indicator 5: Percentage of clients who had a non-medical case management care plan updated two or more times in the measurement year.
	
	Indicator 6: Percentage of client records with documented follow up for issues presented in the care plan.
	
	Indicator 7: Percentage of Care Plans documented in the primary client record system.

Section C: Assistance in Accessing Services and Follow-Up	
Standards Requirement	Monitoring Indicators
Case management staff will work with the client to determine barriers to accessing services and will aid in accessing needed services. Case management staff will ensure that clients are accessing needed services, and will identify and resolve any barriers clients may have in following through with their Care Plan. When clients are aided with services elsewhere (outside of the agency providing NMCM services), case notes include documentation of follow-up.	Indicator 8: Percentage of clients with documentation that the scope of activity includes guidance and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. Indicator 9: Percentage of clients with documented types of assistance provided that was initiated upon identification of client needs and with the agreement of the client. Assistance denied by the client should also be documented in the primary client record system.

	Indicator 10: Percentage of clients with documentation that where benefits/entitlement counseling and referral services are provided, they assist clients in obtaining access to both public and private programs, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other state or local healthcare and supportive services. Indicator 11: Percentage of clients with assistance provided have documentation of follow up to the type of assistance provided.

Section D: Case Closure/Graduation	
Standards Requirement	Monitoring Indicators
Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. Common reasons for case closure include: • Client no longer needs non-medical case management services • Client is referred to another case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • Client death Graduation criteria: • Client completed case management goals for increased access to services/care needs • Client is no longer in need of case management services (e.g. client can resolving needs independent of case management assistance) Client is considered non-compliant with care if three (3) attempts to contact client (via phone, email and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt. Make sure	Indicator 12: Percentage of clients with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary). Indicator 13: Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). Indicator 14: Percentage of clients notified (through face-to-face meeting, telephone conversation, or letter) of plans to discharge the client from case management services. Indicator 15: Percentage of clients with written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the discharge from service. Indicator 16: Percentage of clients with information about reestablishment shared with the client and documented in primary client record system. Indicator 17: Percentage of clients provided with contact information and process for reestablishment as documented in primary client record system. Indicator 18: Percentage of clients with documented Case Closure/Graduation in the primary client record system.

appropriate *Releases of Information and consents are signed by the client and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, email, certified letter) when trying to re-engage a client, as appropriate. *Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI).*	

References

PHS Act § 2604(d)

Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Oral Health (OH) Care

HRSA Service Category Description

Core Service Category

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

Services

Services will include routine dental examinations, prophylaxes, radiographs, restorative therapies, basic oral surgery (e.g., extractions and biopsy), endodontics, 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 client's annual benefit balance.

Limitations

Cosmetic dentistry for cosmetic purposes only is prohibited.

Oral health services are an allowable core service with an expenditure *cap of $3,000/client per calendar year across all grants* (e.g. 1: a client is allowed a grand total of $3,000 for services across Ryan White Part A, Part B, Part D, **and** Operation BRAVE; not $3,000 per grant. e.g. 2: a client does **not** get $3,000 for Part A **and** $3,000 for Part D).

Local service regions may set additional limitations on the type or number of procedures covered and/or may set a lower expenditure cap, so long as such criteria are applied equitably across the region and the limitations do not restrict eligible individuals from receiving needed oral health services outlined in their individualized dental treatment plan.

In the cases of emergency need and/or where extensive care is needed, the maximum amount may exceed the above cap. Dental providers are required to document the reason for exceeding the yearly maximum amount and must have documented approval from the local Administrative Agency.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Oral Health Care - Routine Treatment	Per visit
Oral Health Care - Prophylaxis	Per visit

Oral Health Care - Specialty	Per visit

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Services	
Standards Requirement	Monitoring Indicators
In order to provide equitable, allowable Oral Health services to all eligible clients for successful completion of their individualized dental treatment plans, expenditure caps may be sent with additional limitations so long as the criteria are applied equitably, and limitations do not restrict eligible individuals from receiving needed oral health services. In the cases of emergency need and/or where extensive care is needed, the maximum amount may exceed the above ($3,000/client/calendar year) cap. Dental providers are required to document the reason for exceeding the yearly maximum amount and must have documented approval from the local Administrative Agency (AA) for the purposes of funds only, but not the appropriateness of the clinical procedure.	Indicator 1: Percentage of clients with documented evidence that oral health care services provided met the specific limitations or caps as set forth for dollar amount and any additional limitations as set regionally for type of procedure, limits on number of procedures or combination of these. Indicator 2: Percentage of clients with documented evidence if the cost of dental care exceeded the annual maximum amount for services funding, reason is documented in the patient's oral health care record.

Section B: Medical/Dental History/Screening	
Standards Requirement	Monitoring Indicators
To develop an appropriate treatment plan, the oral health care provider shall obtain complete information about the patient's health and medication status. As per the Texas Board of Dental Examiners, at minimum, a medical history and limited physical evaluation should be obtained and reviewed at the initial appointment and updated annually. This information shall include, but not be limited to, the following: • The client's HIV-prescribing primary medical care provider name and phone number; • Pregnancy status as applicable; • Coagulants; • Patient's chief complaint; • Current Medications, including any osteoporotic medications;	Indicator 3: Percentage of clients who had a dental and medical health history (initial or updated) at least once in the measurement year. (HRSA HAB Measure)

• Allergies and drug sensitivities; • Recreational drug and alcohol use; • Tobacco use; • Neurological diseases; • Usual oral hygiene; and • Date of last dental examination.	

Section C: Limited Physical Examination	
Standards Requirement	Monitoring Indicators
The oral health provider is responsible for completing an initial limited physical examination in accordance with the Texas Board of Dental Examiners that shall include, but not be limited to: • Blood Pressure; • Pulse/Heart Rate; and • Basic vital signs. Dental practitioner shall also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a patient's vital signs, the dental practitioner must document in the patient's oral health care record why the attempt to obtain vital signs was unsuccessful.	Indicator 4: Percentage of clients with a documented limited physical examination completed in the primary client oral health record.

Section D: Oral Examination	
Standards Requirement	Monitoring Indicators
Clinical oral evaluations include evaluation, diagnosis and treatment planning. Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • Comprehensive oral evaluation, to include bitewing x-rays, new or established patient; • Periodic Oral Evaluation to include bitewing x-rays, established patient; • Detailed and Extensive Oral Evaluation, problem focused by report; • Re-evaluation, limited, problem focused (established patient; not post-operative visit); or • Comprehensive Periodontal Evaluation, new or established patient. Source: ada.org ADA Oral Health Topic: HIV.	Indicator 5: Percentage of clients with a documented oral examination completed within the measurement year in the client's primary oral health record.

Section E: Periodontal Screening or Examination	
Standards Requirement	Monitoring Indicators
A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and radiological review of the status of the periodontium and dental implants. A comprehensive periodontal examination includes: • Evaluation of periodontal conditions; • Evaluation and recording of dental caries; • Evaluation and recording of missing or unerupted teeth; • Evaluation and recording of restorations; • Evaluation and recording of occlusal relationships; • Evaluation of oral cancer; • Probing and charting; • Evaluation and recording of the patient's dental and medical history; and • General health assessment. Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. Patients with HIV may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with patients with acquired immune deficiency syndrome.	Indicator 6: Percentage of clients who had a periodontal screen or examination as least once in the measurement year. (HRSA HAB Measure)

Section F: Treatment Plan	
Standards Requirement	Monitoring Indicators
Dental Treatment Plan A dental treatment plan that includes preventive care, maintenance, and elimination of oral pathology shall be developed and discussed with the patient. Various treatment options shall be discussed and developed in collaboration with the patient. A treatment plan appropriate for the patient's health status, financial status, and individual preference must include as clinically indicated: • Provision for the relief of pain; • Elimination of infection; • Preventive plan component; • Periodontal treatment plan if necessary; • Elimination of caries; • Replacement or maintenance of tooth space or function;	Indicator 7: Percentage of clients who had a dental treatment plan developed and/or updated at least once in the measurement year. (HRSA HAB Measure)

• Consultation or referral for conditions where treatment is beyond the scope of services offered; • Determination of adequate recall interval; • Invasive Procedure Risk Assessment (prior to oral surgery, extraction, or other invasive procedure); • Dental treatment plan will be signed by the oral care health professional providing the services. (*Electronic signatures are acceptable*) *Phase 1 Treatment Plan* Phase 1 treatment includes prevention, maintenance, and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: • Restorative treatment; • Basic periodontal therapy (nonsurgical); • Basic oral surgery that includes extractions and biopsy; • Non-surgical endodontic therapy; and • Space maintenance and tooth eruption guidance for transitional dentition. A Phase 1 treatment plan will be established and updated annually to include diagnostic, preventative, and therapeutic services that will be provided. The Phase 1 treatment plan, if the care was completed on schedule, is completed within 12 months of initiating treatment.	Indicator 8: Percentage of clients with a Phase 1 treatment plan that is completed within 12 months. (HRSA HAB Measure)

Section G: Oral Health Education	
Standards Requirement	Monitoring Indicators
Oral health education must be provided and can be documented by either a licensed dentist, dental hygienist, dental assistant, or dental case manager and shall include: • Oral hygiene instruction; • Daily brushing and flossing (or other interproximal cleaning) and/or prosthetic care to remove plaque; • Daily use of over-the-counter fluorides to prevent or reduce cavities when appropriate and applicable to the patient. If deemed appropriate, the reason is stated in the patient's oral health record; and • Smoking/tobacco cessation counseling as indicated. Additional areas for instruction may include Nutrition.	Indicator 9: Percentage clients who received oral health education on oral hygiene instruction at least once in the measurement year. (HRSA HAB Measure) Indicator 10: Percentage clients who received oral health education on daily brushing and flossing (or other interproximal cleaning) and/or prosthetic care to remove plaque at least once in the measurement year. (HRSA HAB Measure) Indicator 11: Percentage of clients who received oral health education on daily use of over-the-counter fluorides at least once in the measurement year. (HRSA HAB Measure) Indicator 12: Percentage of clients who received oral health education on smoking/tobacco cessation counseling as indicated at least once in the measurement year. (HRSA HAB Measure)

For pediatric patients, oral health education shall be provided to parents and caregivers and be age-appropriate for pediatric patients. Source: ada.org or the ADA's website for patient education information.	

Section H: Referrals	
Standards Requirement	Monitoring Indicators
Referrals for other services must be documented in the patient's oral health care chart. Any referrals provided by the oral health provider must have documented evidence of outcomes of the referral and/or follow-up documentation regarding the referral.	Indicator 14: Percentage of clients with documented referrals provided have outcomes and/or follow-up documentation in the primary oral health care record.

References

PHS Act § 2604(c)(3)(D)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Subchapter A, Rule §108.7 Minimal Standards of Care, General

Texas Administrative Code. Title 22, Part 5, State Board of Dental Examiners, Chapter 108, Subchapter A, Rule §108.8, Records of the Dentist

Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection

New York State Department of Health AIDS Institute, Management of Periodontal Disease Accessed October 14, 2020

New York State Department of Health AIDS Institute, Oral Health Complications Accessed October 14, 2020

Outpatient/Ambulatory Health Services (OAHS)

HRSA Service Category Description

Core Service Category

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

Program Guidance

Treatment adherence activities provided during an OAHS visit are considered OAHS services, whereas treatment adherence activities provided during a medical case management visit are considered medical case management services.

Services

Allowable activities include:

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

Care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies (ART).

Diagnostic laboratory testing includes all indicated medical diagnostic testing, including all tests considered integral to treatment of HIV. 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 U.S. Food and Drug Administration (FDA), when required under the FDA Medical Devices Act; and/or (2) performed in an approved 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.

Limitations

Non-HIV related visits to urgent care facilities are not allowable costs under OAHS.

Emergency room visits are not allowable costs within the OAHS category.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Outpatient/Ambulatory Health Services	Per visit
Dermatology	Per visit
Infectious Disease	Per visit
Neurology	Per visit
Ob/Gyn	Per visit
Oncology	Per visit
Ophthalmology	Per visit
Other Specialty	Per visit
Radiology	Per visit
Laboratory - Service Except CD4 and Viral Load Tests	Per test
CD-4 T-Cell Count	Per test
Viral Load Test	Per test

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Physical examination	
Standards Requirement	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should perform a baseline and annual comprehensive physical examination, with attention to areas potentially affected by HIV. Physical examination will include the documentation from the complete review of systems as indicated within the comprehensive medical history. Source: Guide for HIV/AIDS Clinical Care Page 73-77 (PDF)	Indicator 1: Percentage of clients with a documented annual physical examination. Indicator 2: Percentage of clients who received an oral cavity exam during the physical exam as documented in the patient's primary record.

Section B: Comprehensive HIV-related history	
Standards Requirement	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should document a comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines. This can be completed during the initial visit or divided over the course of two or three early visits. History shall consist of, at a minimum, general medical history, a comprehensive HIV related history, and psychosocial history to include: • Documented past medical and surgical history with regard to chronic diseases such as diabetes, high blood pressure, heart disease, cholesterol, asthma or emphysema, sickle cell disease, etc. per HHS guidelines. • Psychosocial history to include socio-cultural assessment, occupational history, hobbies (as applicable), travel history, mental health, and housing status. • Lifestyle including tobacco use, alcohol use, illicit substance use, exercise, travel history. • Sexual Health including partners, practices, past sexually transmitted infections (STIs), contraception use (past and present). • HIV-related health history including most recent CD4 and Viral Load results, current ART (if applicable), previous adverse ART drug reactions, history of HIV-related illness and infections, HIV treatment history and staging. Source: Guide for HIV/AIDS Clinical Care Page 61-70 (PDF)	Indicator 3: Percentage of clients with a documented comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines.

Section C: Laboratory tests, as clinically indicated by licensed provider	
Standards Requirement	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Tests will include as clinically indicated: • HIV Antibody, if not documented previously; • CD4 Count and/or CD4 Percentage • Quantitative Plasma HIV RNA (HIV Viral Load) • HIV Viral Load Suppression • Standard genotypic drug-resistance testing Refer to Table 3 in the "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV" for guidance on other scenarios where genotype testing is recommended • Coreceptor Tropism Test (if considering use of CCR5 co-receptor antagonist or for patients who exhibit virologic failure on a CCR5 antagonist) • HLA-B*5701 testing (only before initiating abacavir-containing regimen per guidelines) • Complete Blood Count (CBC) with Differential and Platelets • Chemistry Profile: Electrolytes, Creatinine, Blood Urea Nitrogen (BUN) • Liver Transaminases, Bilirubin (Total and Direct) • Lipid Profile – random or non-fasting (Total Cholesterol, LDL, HDL, Triglycerides) • Glucose (random or non-fasting) or hemoglobin A1C • Hepatitis A antibody, Hepatitis B surface antigen, core Ab, and surface antibody & Hepatitis C antibody screens at initial intake (providers should screen all HIV-infected patients for anti-HCV antibodies at baseline) ○ Quantitative HCV RNA viral load testing (for Hepatitis C (HCV) positive patients who are candidates for treatment) • Toxoplasma gondii IgG • Pregnancy Test (for clients with a cervix of childbearing potential) • RPR or treponemal antibody (Syphilis Screening) • Gonorrhea (GC) and Chlamydia (CT) Testing • Trichomoniasis Testing Source: Guide for HIV/AIDS Clinical Care Page 79-89 (PDF)	Indicator 4: Percentage of clients with documented CD4 count (absolute). Indicator 5: Percentage of clients with documented HIV-RNA viral load. Indicator 6: Percentage of clients with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. (HRSA HAB Measure) Indicator 7: Percentage of clients who had an HIV drug resistance test performed before or at the time of initiation of ART if therapy started during the measurement year. (HRSA HAB Measure) Indicator 8: Percentage of clients at risk for STIs who had chlamydia testing at all applicable sites within the measurement year. (HRSA HAB Measure) Indicator 9: Percentage of clients at risk for STIs who had gonorrhea testing at all applicable sites within the measurement year. (HRSA HAB Measure) Indicator 10: Percentage of clients who had a test for syphilis performed within the measurement year. (HRSA HAB Measure) Indicator 11: Percentage of clients with documented evidence that a Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity. (HRSA HAB Measure) Indicator 12: Percentage of clients for whom HCV screening was performed at least once since the diagnosis of HIV. (HRSA HAB Measure) Indicator 13: Percentage of clients with a Hepatitis C RNA viral load test, as applicable, completed within the measurement year. Indicator 14: Percentage of clients who were prescribed ART and who had a random or fasting lipid panel at least once since diagnosis of HIV. (HRSA HAB Measure) Indicator 15: Percentage of clients with documented laboratory tests completed according to the OAHS Standard and HHS treatment guidelines.

Section D: Immunizations	
Standards Requirement	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Immunizations/vaccinations will be given according to the most current HHS guidelines and the CDC's "Table 2: Recommended Adult Immunization Schedule by Medical Condition and Other Indications, US 2020." Providers will initiate prophylaxis for specific opportunistic infections. Patients will be offered vaccinations for the following: • Tetanus, Diphtheria, and Pertussis (Tdap) per recommended treatment guidelines for immunizations • Measles, Mumps, Rubella (MMR) per recommended treatment guidelines for immunizations. *Adults and adolescents with a CD4 cell count <200 cells/uL should not receive MMR*. • Influenza (inactivated vaccine)- annually during flu season October 1st - March 31st • Pneumococcal is recommended for all patients, two separate vaccines are recommended; ○ Receive a dose of PCV13, (Prevnar 13), followed by a dose of PPV23 (Pneumovax) at least eight (8) weeks later. • Completion of Hepatitis B (HBV) vaccines series, unless otherwise documented as immune, vaccinated patients should be tested for HBsAb response 1–2 months after completed the series or at the next scheduled clinic visits after completing the series. • Completion of Hepatitis A (HAV) vaccines series, unless otherwise documented as immune. • Varicella-Zoster (VZV): Please reference current treatment guidelines for VZV. **This vaccination is contraindicated in persons with HIV and CD4 count <200*. • COVID 19 vaccine. * HPV vaccine: The 2019 Advisory Committee on Immunization Practices (ACIP) recommends and DHHS states: "because of the potential benefit in preventing HPV-associated disease and cancer in this population, HPV vaccination is recommended for HIV infected males and females aged 11 through 26, but can be initiated as early as 9 years of age. For persons 27-45, ACIP recommends a conversation between provider and client regarding vaccine for this age group.	Indicator 16: Percentage of clients with Tetanus, Diphtheria, and Pertussis current within 10 years, Td booster doses every 10 years thereafter, or documentation of refusal. Indicator 17: Percentage of clients seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization OR documentation of refusal. (HRSA HAB Measure) Indicator 18: Percentage of clients who completed the vaccination series for Hepatitis B, or documentation of refusal. Indicator 19: Percentage of clients who ever received pneumococcal vaccine, or documentation of refusal. Indicator 20: Percentage of clients who completed the vaccination series for Hepatitis A, or documentation of refusal. Indicator 21: Percentage of clients that are age >50 with a CD4>200 who ever received the Zoster (or RZV, Shingrix) vaccine, or documentation of refusal. Indicator 22: Percentage of clients who ever received a COVID 19 vaccine OR who reported previous receipt of a COVID 19 vaccine, or documentation of refusal. Indicator 23: Percentage of clients between the ages of 11 and 26 years (can be initiated as early as 9 years of age) who completed the series for HPV, or documentation of refusal.

Section E: Anti-retroviral Therapy (ART)	
Standards Requirement	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. ART will be prescribed in accordance with the HHS established guidelines. Patients who meet current guidelines for ART are offered and/or prescribed ART. Source: Guide for HIV/AIDS Clinical Care (ARV) Page 207-220 (PDF)	Indicator 24: Percentage of clients are prescribed antiretroviral therapy (ART) for the treatment of HIV during the measurement year. (HRSA HAB Measure)

Section F: Screenings/Assessments	
Standards Requirement	Monitoring Indicators

Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.
 	
Patients should receive screening for opportunistic infections and assessment of psychosocial needs initially and annually according to the most current HHS guidelines.
 	
Screening should include at a minimum:
• Mental health assessment that includes screening for clinical depression (PHQ 2 at a minimum)
• Psychosocial assessment, including domestic violence and housing status (housing status noted as: stable housing, unstable housing, or homeless)
• Substance use and abuse screening
• Tobacco use screening
• Pediatric patients (aged 14 and younger) will be screened for child abuse as defined in Chapter 261 of the Texas Family Code and DSHS policy. Consider screening youth 14-17 for child abuse.
• Oral health exam and assessment
• Tuberculosis (TB) Screening
• Cervical Cancer Screen (*following the most current clinical recommendations*)
  ○ *Clients with a cervix Aged <30 Years with HIV:*
  ▪ If younger than age 21, known to have HIV or newly diagnosed with HIV, and sexually active, Pap test
	Indicator 25: Percentage of clients with documented medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines.
	
	Indicator 26: Percentage of clients with a cervix who were screened for cervical cancer in the last three years. (HRSA HAB Measure)
	
	Indicator 27: Percentage of clients aged 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool. (HRSA HAB Measure)
	
	Indicator 28: Percentage of clients aged 12 and older with positive clinical depression screen with follow-up plan documented on the date of the positive screen. (HRSA HAB Measure)
	
	Indicator 29: Percentage of clients who were screened for domestic violence at least once during the measurement year.
	
	Indicator 30: Percentage of clients who received a housing status assessment to determine if they are experiencing housing instability or homelessness, at least once during the measurement year.
	
	Indicator 31: Percentage of clients who have been screened for substance use (alcohol & drugs) in the measurement year. (HRSA HAB Measure)

should be performed within one (1) year of onset of sexual activity regardless of mode of HIV transmission.

- *Clients with a cervix Aged >30 Years with HIV*
  - Pap test should be done at baseline and every 12 months. If results of three (3) consecutive Pap tests are normal, follow-up Pap tests can be performed every three (3) years.

Additional screenings as medically indicated include:

- Dilated eye exam every 6 to 12 months if the CD4 <50 by an ophthalmologist

Anal Cancer (Dysplasia) Screening

The Anal Cancer (Dysplasia) Screening Guidelines recommend, at a minimum, annual digital examination to detect masses on palpation that could be anal cancer. However, performing the digital exam alone as a screening procedure for anal dysplasia or cancer will miss many lesions. Anal cancer screening using a Pap test can improve sensitivity for detecting anal dysplasia or cancer. Cytology combined with high-resolution anoscope (HRA) is considered the best strategy for screening of precancerous lesions. If anal Pap is performed, clinicians should refer patients with abnormal anal cytology for HRA. In communities where HRA is not available, clinicians should consider referring patients with abnormal anal cytology to a surgeon for evaluation.

Source: Guide for HIV/AIDS Clinical Care Page 6-7, 83-89, 127 (PDF)

Recommended: Guide for HIV/AIDS Clinical Care Psychosocial Assessment Questions: page 65 (PDF)

Cervical Cancer Screen

Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.

Chest x-ray will be completed if pulmonary symptoms are present; if positive LTBI test (either TST or Interferon Gamma Release Assay (IGRA)); or if prior evidence of LTBI or pulmonary TB (perform annually).

Source: Guide for HIV/AIDS Clinical Care Page 85 (PDF)

Indicator 32: Percentage of clients aged 18 years and older who were screened for tobacco use one or more times within 24 months. (HRSA HAB Measure)

Indicator 33: Percentage of clients, if applicable, with completed child abuse assessment (completed if patient aged 14 and younger).

Indicator 34: Percentage of clients who has documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV. (HRSA HAB Measure)

Indicator 35: Percentage of clients with documented chest x-ray completed if pulmonary symptoms were present, after an initial positive QTF, after initial positive TST, or annually if prior evidence of LTBI or pulmonary TB.

Section G: Health Education/Risk Reduction	
Standards Requirement	Monitoring Indicators
Health education will adhere to the most current HHS guidelines. Providers will provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients. Since patients' behaviors change over time as the course of their disease changes and their social situations vary, health education providers will tailor routine risk-reduction counseling and behavioral health counseling not only to the individual patient but also to the point in time in the patient's life. The following will be conducted initially and as needed: • Providers should discuss safer sexual practices so to decrease risk of transmitting HIV. • Providers should counsel HIV-infected patients about the risk of acquiring syphilis and other STIs from unprotected sexual contact, including all sites of possible transmission, such as anus, cervix, vagina, urethra, and oropharynx. • Providers should discuss family planning with patients • Contraception counseling/hormonal contraception • Drug interaction counseling • Providers should counsel patients on tobacco cessation annually for those patients that were screened and positive for smoking (or document decline of tobacco use) • When current alcohol or other substance use is identified, providers should discuss the possible effects of such use on the patient's general health and HIV medications, as well as options for treatment if indicated • Providers should routinely discuss with patients the importance of disclosure to partners. Patients should be educated about the options for voluntary partner notification. • When HIV patients are diagnosed with early syphilis (primary, secondary, or early latent), providers should intensify risk-reduction counseling, including discussions about the importance of condom use. • Nutritional Counseling regarding: ○ Quality and quantity of daily food and liquid intake	Indicator 36: Percentage of clients who received HIV risk counseling in the measurement year. (HRSA HAB Measure) Indicator 37: Percentage of clients aged 18 years and older who received cessation counseling intervention if identified as a tobacco user. (HRSA HAB Measure) Indicator 38: Percentage of clients with documented counseling about family planning method appropriate to patient's status, as applicable, to include preconception counseling. Indicator 39: Percentage of clients with documented instruction regarding new medications, as appropriate. Indicator 40: Percentage of clients with documented counseling regarding the importance of disclosure to partners.

○ Exercise (as medically indicated) Source: Guide for HIV/AIDS Clinical Care (Smoking Cessation) page 189-196 (PDF) Source: Guide for HIV/AIDS Clinical Care (Patient Education) Page 57-59, 89, 102, 107, 111, 126, 143-154 (PDF) Source: Guide for HIV/AIDS Clinical Care (Nutrition) Page 197-202 (PDF)	

Section H: Treatment Adherence	
Standards Requirement	Monitoring Indicators
Assessment of treatment adherence and counseling will be provided that adheres to current HHS guidelines. Patients are assessed for treatment adherence and counseling at a minimum of twice a year. Those who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. If adherence issue is identified by another member of the healthcare team (MCM, MA, LVN, RN), there is documented evidence of adherence counseling and follow-up action. This adherence counseling documentation must be evident in the patient's medical record and clearly indicated that the prescribing provider was made aware of the adherence issue. Source: Guide for HIV/AIDS Clinical Care Page 273 (PDF)	Indicator 41: Percentage of clients with documented assessment for treatment adherence two or more times within the measurement year if patient is on ART. Indicator 42: Percentage of clients with documented adherence issues who received counseling for treatment adherence two or more times within the measurement year. Indicator 43: Percentage of clients who had a medical visit in the last 6 months of the measurement year (that is documented in the medical case management record). (HRSA HAB measure) Indicator 44: Percentage of clients who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (HRSA HAB Measure)

Section I: Referrals	
Standards Requirement	Monitoring Indicators
Providers will refer to specialty care or other systems as appropriate in accordance with current HHS guidelines. At a minimum, patients should receive referrals to specialized health care/providers/services *as needed or medically indicated* to augment medical care: • AIDS Drug Assistance Program (ADAP) • Medication Assistance Programs • Medical care coordination • Medical specialties	Indicator 45: Percentage of clients, as medically indicated, who had documentation of referrals for Mental Health and/or Substance Use. Indicator 46: Percentage of clients, as medically indicated, who had documentation of referrals for Oral Health. Indicator 47: Percentage of clients, as medically indicated, who had documentation of referrals for Ophthalmological services.

• Mental health and substance use services - Treatment education services
• Partner counseling and referral
• Annual oral hygiene and intraoral examinations, including dental caries and soft-tissue examinations.
• Medical Nutrition Therapy (MNT)
• Health maintenance, as medically indicated, such as:
  ○ Cervical Cancer Screening
  ○ Family Planning
  ○ Colorectal cancer screening
  ○ Breast cancer screening
• Specialty medical care for any preexisting chronic diseases
• Case Management Services or a Disease Investigation Specialist (DIS) for follow-up if missing appointments.
• Vision Care
• Audiology
 	
Providers/staff are expected to follow-up on each referral to assess attendance and outcomes. For specific details regarding screening modalities and timeframes see The United States Preventive Services Task Force.
 	
Source: Guide for HIV/AIDS Clinical Care Page 73 (PDF)
	Indicator 48: Percentage of clients, as medically indicated, who had documentation of referrals for Child abuse if suspected abuse.
	
	Indicator 49: Percentage of clients, as medically indicated, who had documentation of referrals for Disease intervention specialist.
	
	Indicator 50: Percentage of clients, as medically indicated, who had documentation of referrals for Other specialty services.
	
	Indicator 51: Percentage of clients with a documented referral in the measurement year, has a progress note in the patient's chart regarding attendance, and outcomes of the referral.

Section J: Documentation in Patients' Medical Chart	
Standards Requirement	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Clinicians (included but not limited to Providers with prescriptive authority, PharmD, PhD, LCSW, LCDC, RN, LVN, MA or MCM) will develop/ update plan of care at each visit. If a patient refuses a treatment, such as vaccinations, documentation of denial will be written in the patient's medical chart. The provider developing the plan will sign each entry, an electronic signature is allowable. Source: Guide for HIV/AIDS Clinical Care See Section 2, Page 77 (PDF)	Indicator 52: Percentage of client's medical records with signed clinician entries. Indicator 53: Percentage of flow sheets (vitals) present and updated in the client's medical records, if applicable. Indicator 54: Percentage of problem lists present and updated in the client's medical records. Indicator 55: Percentage of medication lists present and updated in the client's medical records.

Section K: Documentation of missed patient appointments & efforts to bring them into care	
Standards Requirement	Monitoring Indicators
Provider and/or staff will conduct the following: • Contact patients who have missed appointments, using at least 3 different forms of contact (phone, mail, emergency contact, phone call, referral to DIS for home visit) prior to determining they are lost to follow-up; • Address any specific barriers to accessing services; • Document number of missed patient appointments and efforts to bring the patient into care. Source: Guide for HIV/AIDS Clinical Care Page 1 (PDF)	Indicator 56: Percentage of client with documentation of any specific barriers and efforts made to address missed appointments.

Section L: Diagnostic Testing to Exclude HIV Infection in Exposed Infants	
Standards Requirement	Monitoring Indicators
Newborns Born to Mothers Who Received Antepartum/Intrapartum Antiretroviral Drugs with Effective Viral Suppression: According to US Department of Health and Human Services, (DHHS) the risk of HIV acquisition in newborns born to women who received ART regimens during pregnancy and labor and had undetectable viral loads at delivery is <1%. DHHS recommends a 4-week neonatal zidovudine prophylaxis regimen for newborns if the mother has received ART during pregnancy with viral suppression (usually defined as confirmed HIV RNA level below the lower limits of detection of an ultrasensitive assay) at or after 36 weeks' gestation, and there are no concerns related to maternal adherence. *Newborns Born to Mothers with Unknown HIV Status at Presentation in Labor* • Expedited HIV testing is recommended during labor for women with unknown HIV status and, if not performed during labor, as soon as possible after birth for the mothers and/or their newborns (see Identification of Perinatal Exposure). Expedited test results should be available within 60 minutes. • If maternal or infant expedited testing is positive, the newborn *should be immediately initiated on a multi-drug ARV prophylaxis regimen or empiric HIV therapy*, without waiting for the results of supplemental tests • Expedited HIV testing should be available on a 24-hour basis at all facilities with a maternity	Indicator 57: Percentage of infants born to people living with HIV who received recommended virologic diagnostic testing for exclusion of HIV infection in the measurement year. (HRSA HAB Measure)

service and/or neonatal intensive care unit or special care or newborn nursery • A nursing mother who is suspected of having HIV based on an initial positive antibody or antibody/antigen test result should stop breastfeeding until HIV is confirmed or ruled out • Breastfeeding is not recommended for women with confirmed HIV in the United States, including those receiving ART *Newborns Born to Mothers with Antiretroviral Drug-Resistant Virus* • The optimal ARV regimen for newborns delivered by women with ARV drug-resistant virus is unknown. The ARV regimen for newborns born to mothers with known or suspected drug resistance should be determined in consultation with a pediatric HIV specialist before delivery or through consultation via the National Perinatal HIV Hotline (888-448-8765) • Data exist to provide dosing recommendations appropriate for the treatment of HIV in neonates For comprehensive guidance please see Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection	

References

PHS Act § 2604(c)(3)(A)

Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, June 3, 2021

Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States, October 26, 2016

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HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 07-02: Use of Ryan White HIV/AIDS Program Funds for HIV Diagnostics and Laboratory Tests Policy 2002 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

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New York State Recommendations on Anal Pap Smears

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Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission. Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States (PDF) Accessed October 2020.

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U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Rockville, MD: U.S. Department of Health and Human Services, page 81, 85. (PDF)

Primary Care Guidelines for Management of HIV. CID 2014:58 (1 January)

Recommended Immunization Schedule for Adults Aged 19 Years or Older. United States. 2020 Advisory Commission on Immunization Practices (ACIP), Table 1

Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents. DHHS, 2020

Referral for Health Care and Support Services (RHSS)

HRSA Service Category Description

Support Service Category

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

Program Guidance

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

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

<table>
<tr><th>MCM Examples</th><th>NMCM Examples</th><th>RHSS Examples (No MCM/NMCM)</th></tr>
<tr><td>Requires assistance with achieving or maintaining viral suppression</td><td>Advice and assistance in obtaining medical, social, community, legal, financial and other needed services</td><td>Clients who do not need case management but require a voucher for a service</td></tr>
<tr><td>Follow-up of Medical Treatments: includes either accompanying client to medical appointments</td><td rowspan="3">Providing specific services such as housing assistance or transportation are not case management; but identifying and arranging to have that assistance provided is case management</td><td>Needs help with transportation for medical appointments</td></tr>
<tr><td rowspan="2">Treatment Adherence: the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments</td><td>Client requires general financial assistance</td></tr>
<tr><td>Client needs referrals for health services</td></tr>
</table>

Services

Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible clients to obtain access to other public and private programs for which they may be eligible.

Benefits counseling: Services should facilitate a client's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting clients in identifying all available health and disability benefits supported by funding streams other than Ryan White Part A Program funds. Clients should be educated about and

assisted with accessing and securing all available public and private benefits and entitlement programs.

Health care services: Clients should be provided assistance in accessing health insurance or Marketplace health insurance plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting client's entry into and movement through the care service delivery network such that Ryan White Program funds are Payor of Last Resort (PoLR).

Limitations

Funds cannot be used to duplicate referral services provided through other service categories. Please reference the HRSA Program Guidance above.

Taxonomy

The following taxonomy are the allowable "Subcategory" and "Service Units" that are to be used in the e2SanAntonio, the Recipient's Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Referral to health care/supportive services	Per referral

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Benefits Counseling	
Standards Requirement	Monitoring Indicators
Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure clients are receiving all needed public and/or private benefits and/or resources for which they are eligible. Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources.	Indicator 1: Percentage of clients with documented evidence of education provided on other public and/or private benefit programs in the primary client record. Indicator 2: Percentage of clients with documented evidence of other public and/or private benefit applications completed as appropriate within 14 business days of the eligibility determination date in the primary client record. Indicator 3: Percentage of clients with documented evidence of the follow-up and result(s) to a completed benefit application in the primary client record.

Staff will explore the following as possible options for clients, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/ HIPP, COBRA, OBRA, State Health Insurance Assistance Plans (SHIPs), Medicaid, Medicare, Private, ACA/Marketplace) • SNAP • Pharmaceutical Patient Assistance Programs (PAPS) • Social Security Programs (Social Security Income (SSI), Social Security Disability Insurance (SSDI)) • Temporary Aid to Needy Families (TANF) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Other public/private benefits programs • Other professional services Staff will assist eligible clients with completion of benefits application(s) as appropriate within 14 business days of the eligibility determination date. Conduct a follow-up within 90 days of completed application to determine if additional and/or ongoing needs are present.	

Section B: Health Care Services	
Standards Requirement	Monitoring Indicators
Clients should be assisted in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Eligible clients are referred to Health Insurance Premium and Cost-Sharing Assistance (HIPCSA) to assist clients in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake. Eligible clients are referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. Eligible clients are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services.	Indicator 4: Percentage of clients with documented evidence of assistance provided to access health insurance or Marketplace plans in the primary client record. Indicator 5: Percentage of clients who received a referral for other core services and/or support services who have documented evidence of the education provided to the client on how to access these services in the primary client record. Indicator 6: Percentage of clients with documented evidence of referrals provided for HIPCSA assistance that had follow-up documentation within 10 business days of the referral in the primary client record. Indicator 7: Percentage of clients with documented evidence of referrals provided to any core services and/or support services that had follow-up documentation within 10 business days of the referral in the primary client record.

Staff will follow-up within 10 business days of a referral provided to HIA to determine if the client accessed HIA services. Staff will follow-up within 10 business days of a referral provided to any core services to ensure the client accessed the service. Staff will follow up within 10 business days of a referral provided to support services to ensure the client accessed the service.	

Section C: Case Closure Summary	
Standards Requirement	Monitoring Indicators
Clients who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the client primary record. The case closure summary must include a brief synopsis of all services provided and the result of those services documented as 'completed' and/or 'not completed.'	Indicator 8: Percentage of clients who are no longer in need of assistance through Referral for Health Care and Support Services that have a documented case closure summary in the primary client record.

References

PHS Act § 2604(d)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Substance Abuse Outpatient (SA-O) Care

HRSA Service Category Description

Core Service Category

Substance Abuse Outpatient Care (SA-O) is the provision of outpatient services for the treatment of drug or alcohol use disorders.

Program Guidance

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA Ryan White Program, is included in a documented plan. For Ryan White Program funded providers, acupuncturists must be licensed, and therapeutic treatments provided involve the use of sterile, disposable acupuncture needles.

Services will be provided in accordance with Texas Health and Safety code, title 6, Subtitle B, Chapter 464. Counseling and education will be completed in accordance with Texas Health and Safety Code for Substance Abuse Programs.

Services

Activities under Substance Abuse Outpatient Care service category include:

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

Limitations

No use of Ryan White Program funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs. Please reference the Texas Health and Safety Code, Title 6, Subtitle C, Chapter 481, Subchapter A General Provisions.

Taxonomy

The following taxonomy are the allowable “Subcategory” and “Service Units” that are to be used in the e2SanAntonio, the Recipient’s Data System, and TCT, DSHS Data System.

Subcategory	Service Units
Substance Abuse Services – Outpatient-Individual Counseling	Per visit
Substance Abuse Services – Outpatient-Group Counseling	Per visit
Substance Abuse – Intake • Includes but not limited to intake into methadone or other medication-assisted treatment. May include substance abuse assessments (SASSI) by appropriately qualified personnel, although technically, a person is not in outpatient or any form of treatment at the time of the assessment.	Per visit
Medication-Assisted Detox • Includes medications such as Methadone, Subut (buprenorphine hydrochloride) and Suboxone (buprenorphine hydrochloride and naloxone hydrochloride), ORLAAM, etc	Per visit
Substance Abuse Medication Maintenance	Per visit

Standards Requirements & Monitoring Indicators

The following Standards Requirements and Monitoring Indicators are the contractually required guidelines for this service category and the indicators that will be monitored by the University Health Ryan White Program Administration to ensure compliance with the guidelines. The Ryan White Program Administration expects an 80% Compliance Rate for each individual Indicator. Any individual Indicator that falls below the 80% during the monitoring period will be marked as "Needs Improvement" and the Subrecipient may be required to submit a Corrective Action Plan (CAP).

Section A: Initial Appointment/Screening	
Standards Requirement	**Monitoring Indicators**
Face to face client orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. In accordance with Texas Administrative Code (TAC), clients will be informed of opportunities for family to be involved in the client's treatment. An appointment will be scheduled within a reasonable amount of time but not greater than 10 business days from a client's request for substance use services. The agency may provide written orientation materials to the client that supports the above information and is culturally sensitive and linguistically appropriate. In urgent, non-life-threatening emergency circumstances, an appointment will be made as soon	Indicator 1: Percentage of clients with documentation of an appointment scheduled, after request (referral) for substance use outpatient services. Indicator 2: Percentage of clients with documentation of completed screening as indicated.

as possible but no later than within one (1) business day, subject to licensure requirements. If an agency cannot provide the needed services, the agency will offer to refer the client to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s). Each client must have a documented screening completed based on best practice standards of care with use of the Texas Department of Insurance criteria per TAC standards. The screening process shall collect information necessary to determine the type of services that are required to meet the client's needs.	

Section B: Comprehensive Psychosocial Assessment	
Standards Requirement	Monitoring Indicators
All clients referred to the program will receive a Comprehensive Psychosocial Assessment (in accordance with TAC Standards) by a licensed substance use counselor. Initial comprehensive psychosocial assessment protocols shall provide for screening individuals to determine level of need and appropriate development of treatment plan. A comprehensive psychosocial assessment will be completed prior to the third counseling session* and will include the following: • Presenting problems resulting in need; • Alcohol and other substance use; • Psychiatric and chemical dependency treatment; • Medical history and current health status, to include an assessment of Tuberculosis (TB), HIV, and other sexually transmitted infections (STI) risk behaviors as permitted by law; • Relationships with family including domestic/intimate partner violence; • History of trauma/related events; • Stigma; • Housing stability, expelled from home; • Treatment adherences (e.g. HIV meds); • Social and leisure activities; • Education and vocational training; • Employment history; • Legal issues; • Mental/emotional functioning; and • Strengths and challenges. Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening	Indicator 3: Percentage of clients that have documentation of initial comprehensive assessments completed as indicated. Indicator 4: Percentage of clients with documented use of assessment tools as indicated for substance use and sexual history. Indicator 5: Percentage of clients with documented use of assessment tool as indicated for cognitive assessment.

The assessment shall result in a diagnosed substance use issue, as allowed by the license and scope of practice of the counselor. **Note*: Clients are assessed for care coordination needs, and referrals are made to other case management programs as appropriate. If pressing needs emerge during the assessment requiring immediate attention that results in the assessment not finalized by the third session, this must be documented in the client's primary record. Specific assessment tools such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) (PDF) and Addiction Severity Index (ASI) may be used for substance use and sexual history, and the Mini Mental State Examination (MMSE) may be used for cognitive assessment. A copy of the assessment(s) will be offered/provided to the client.	

Section C: Treatment Modalities	
Standards Requirement	Monitoring Indicators
Providers must discuss treatment options with clients who use substances and should ask which treatment options they prefer. Providers should inquire about use of multiple substances and should consider the full spectrum of the client's drug use when discussing treatment options with the client. Providers must discuss alternative treatment modalities with the client that are targeted toward the substance(s) that the client is still using. Providers must rely on the Patient Placement Criteria of the American Society of Addiction Medicine (ASAM) for guidance on selecting the best treatment alternatives for specific clients. Medical treatment for substance use must adhere to current HIV Clinical Guidelines. For medication-assisted therapies (e.g. methadone, suboxone) treatment, client charts will document contact with the client's medical provider within 72 hours of initiation of methadone/suboxone to inform the medical provider of the new prescription or client refusal to authorize this communication.	Indicator 6: Percentage of clients with documentation of discussion of treatment modalities with the client. Indicator 7: Percentage of clients, for clients on medication-assisted therapies, with documentation of contact with client's medical provider within 72 hours of treatment initiation or the client's refusal to authorize the communication. Indicator 8: Percentage of clients with acupuncture services rendered with documented evidence of a physician's order. Indicator 9: Percentage of clients with acupuncture services rendered with documentation that the acupuncture provider has the appropriate state license and certification. Indicator 10: Percentage of clients with acupuncture services rendered with documentation that acupuncture is not the dominant treatment modality. Indicator 11: Percentage of clients with acupuncture services rendered with documentation that the use of funds for acupuncture services is limited through some form of a defined cap.

Treatment for non-pharmacologic treatment modalities may include, but are not limited to, Twelve-Step Programs and Acupuncture. All acupuncture services will be performed in accordance with the Acupuncture Act § 205.001(2)(A) and TAC Title 22, Chapter 9, §183.1.	

Section D: Treatment Plan	
Standards Requirement	Monitoring Indicators
A treatment plan shall be completed within 30 calendar days of completed comprehensive psychosocial assessment specific to individual client needs. The treatment plan shall be prepared and documented for each client. Treatment planning will be a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies for achieving them. Individual, and family case records will include documentation of the following: • Identification of the identified substance use disorder • Goals and objectives • Treatment modality (group or individual) • Start date for substance use counseling • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up Treatment, as appropriate, will include counseling about (at minimum): • Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals The treatment plan will be signed by the substance use counselor rendering service. In accordance with TAC on Substance Abuse, the treatment plan shall be reviewed at a minimum	Indicator 12: Percentage of clients that have documentation of treatment plans completed within 30 calendar days of the completed comprehensive assessment. Indicator 13: Percentage of clients that have documentation of treatment plans include the quantity, frequency, and modality of treatment provided. Indicator 14: Percentage of clients that have documentation of treatment plans include the date treatment begins and ends. Indicator 15: Percentage of clients that have documentation of treatment plans include regular monitoring and assessment of client progress. Indicator 16: Percentage of clients that have documentation of treatment plans include the signature of the individual providing the service and/or the supervisor, as applicable. Indicator 17: Percentage of clients with documented evidence of treatment plans reviewed/modified at minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

midway through the number of determined sessions agreed upon for frequency of modality and must reflect ongoing reassessment of client's problems, needs and response to therapy.	

Section E: Progress Notes	
Standards Requirement	Monitoring Indicators
Services will be provided according to the individual's treatment plan and documented in the client's record. Progress notes are completed for every professional counseling session and include: • Client name • Session date • Clinical observations • Focus of session • Interventions • Assessment • Duration of session • Newly identified issues/goals • Client's responses to interventions and referrals • HIV medication adherence • Substance use treatment adherence • Counselor authentication, in accordance with current TAC standards of care for substance abuse services.	Indicator 18: Percentage of clients with documented progress notes for each counseling session as indicated.

Section F: Referrals	
Standards Requirement	Monitoring Indicators
Agency will make appropriate referrals out when necessary.	Indicator 19: Percentage of clients, as applicable, with documented referrals made based on need demonstrated in the assessment and/or progress notes.

Section G: Discharge Planning	
Standards Requirement	Monitoring Indicators
Discharge planning will be done with each client when treatment goals are met and include: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Referral after completing substance use treatment to case manager and/or primary care provider, as appropriate • Discharge plan • Counselor authentication, in accordance with TAC Standards and the counselor licensure requirements.	Indicator 20: Percentage of clients with documentation, as applicable, of discharge planning with the client prior to case closure.

In all cases, providers/case managers shall ensure that, to the greatest extent possible clients who leave care are linked with appropriate services to meet their needs.	

Section H: Discharge Summary	
Standards Requirement	Monitoring Indicators
Services may be discontinued when the client has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period. • Continued non-adherence to treatment plan • Chooses to terminate services • Unacceptable client behavior • Deceased Completed discharge summary, in accordance with TAC Standards (§448.805), as applicable.	Indicator 21: Percentage of clients with documentation of case closure (discharge) and reason for discharge, or discharge summary if applicable.

References

PHS Act § 2604(c)(3)(L)

45 CFR § 75.364

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals & Allowable Uses of Funds Revised 10/22/2018 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds Frequently Asked Questions 01/22/2016 (PDF)

HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients Revised June 2022 (PDF)

Department of State Health Services Substance Abuse Treatment Facilities

AIDS Institute, Clinical Guidelines Program, Substance Use Accessed on October 14, 2020.
Texas Administrative Code, Title 22, Part 30, Chapter 681 - Texas Board of Examiners of Professional Counselors

Texas Administrative Code, Title 25, Part 1, Chapter 448

Food, Drugs, Alcohol, and Hazardous Substances, Subtitle B. Alcohol and Substance Programs, Chapter 464

Texas Administrative Code, Title 25. Part 1, Chapter 448 Standards of Care, Subchapter H Screening and Assessment
Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening

Texas Administrative Code, Title 22, Part 8, Chapter 193, Acupuncture

Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.805, Discharge