

Approved Ryan White Direct Care Service Guidelines

Based on Funds Availability

I. Purpose

The purpose of these guidelines is to define the allowable services for Area 12 (Volusia and Flagler counties), to document local additional standards that have been approved by the Area 12 Ryan White (RW) consortium, Partnership for Comprehensive HIV/AIDS Planning (PCHAP).

II. Payer of Last Resort

Funds may not be used to provide items or services that have already been paid or can reasonably be expected to be paid by third party payers, including Medicaid, Medicare, other state or local entitlement programs, prepaid health plans, or private insurance. It is therefore incumbent upon providers to ensure that eligible individuals are expeditiously enrolled in Medicaid and that Part B funds are not used to pay for any Medicaid-covered services for Medicaid enrollees. It is also important to ensure that providers pursue Medicaid and other third-party payment when covered services are provided to beneficiaries of other programs. For example, if an applicant is eligible for Medicaid, then the provider should retroactively bill Medicaid for Part B services provided during the time that eligibility was being determined. (2017-2018 Patient Care Program Administrative Guidelines)

In areas where other HIV/AIDS funding is available, such as Patient Care Network (PCN) or Housing Opportunities for People with AIDS (HOPWA), Part B does not require that each of these funding sources be exhausted prior to accessing Part B. Payment for eligible services should be coordinated across these funding streams. Technical assistance regarding payer of last resort issues is available from each area's lead agency, contract manager, and HIV/AIDS planning coordinator. (2017-2018 Patient Care Program Administrative Guidelines)

III. Retained in Care

Area 12 will define "Retained in Care" as having, in the past 12-month period, at least one medical visit in each 6-month period with a minimum of 60 days between medical visits and at least one CD4/VL measurement in each 6-

month period with a minimum of 90 days between counts, as defined by the Florida Department of Health's (FDOH) HIV/AIDS strategic plan.

IV. Pre-Existing Medical Conditions

Clients will not be denied access to HIV/AIDS Patient Care Programs for pre-existing health conditions.

V. Outpatient Ambulatory Health Services

Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including 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

Additional PCHAP Guidelines

1. A phenotyping test is allowable once in a twelve-month period and will be billed at the current contracted price. Approval for more than one phenotyping within a twelve-month period will require a written exception request to the Lead Agency, including documentation of an adherence review from the individual's physician.

2. Clients needing services not in the patient care guidelines will be reviewed on a case by case basis and approved by the Area 12 Lead Agency.

VI. Oral Health (Dental Care)

Oral Health Care provides outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Additional PCHAP Guidelines

1. All new RW eligible clients (and those who have not had a preventative dental visit with an outside provider within the last 6 months), for whom Ryan White is the payer of last resort and are retained in care, will be offered the option to receive preventative services (oral exam, cleaning, x-rays) at FDOH-Volusia or Flagler dental clinics ONLY. After their initial oral health visit, if the services needed exceed the capabilities of the FDOH-Volusia or FDOH-Flagler dental clinics, a referral and authorization will be provided by the case manager to an outside provider based on the client's need. Clients who are being seen by an outside dental provider AND who have received one or more preventative dental service in the last twelve months, may continue to receive care from that provider.
2. Apart from initial visits, a comprehensive treatment plan and x-rays must be received prior to authorizing all additional dental services. Non-preventative dental services will only be provided if determined to be medically necessary, related to loss/reduction of function, inability/difficulty chewing or swallowing, infection, and/or pain. These services include:
 - Periodic oral exam with cleaning (twice a year)
 - X-rays (once a year)
 - Full mouth scaling (once a year)
 - Tooth extractions
 - Restorative fillings
 - Incision and drain procedures
3. For extensive services (i.e. crowns, root canals, full/partial dentures, denture realignment) and services exceeding the annual allowable \$3,000 per client (one-year period begins with client's first visit), detailed progress notes and treatment justification signed by the provider must be submitted to the case manager and approved by the Lead Agency.

4. \$3000 allowable per client per year. Approval to exceed that amount requires a written exception and approval through the Lead Agency. (One-year period begins with client's first visit)

5. RW funding may be utilized for clients who have private dental insurance.

6. Clients will be responsible for abiding to their provider's missed appointment policy and will be held to the terms of that policy. Additionally, a client who is a "no show" two times will result in forfeiture of dental services for a period of six months.

VII. Emergency Financial Assistance (EFA)

Emergency Financial Assistance is limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

VIII. Health Insurance Assistance

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

1. Paying health insurance premiums to provide comprehensive HIV treatment.
2. Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients, and/or
3. Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients, and/or
4. Paying cost sharing on behalf of the client.

Service Limitations:

5. Insurance co-pays and deductibles are limited based on funds availability only for Ryan White approved services.
6. Individuals possessing Medicaid coverage, Medicare coverage (Part A, B & D) or Medicare Supplemental policies are not eligible for Health Insurance Assistance.
7. Individuals who become eligible for Medicare and/or Medicaid at any time must be dis-enrolled from the Health Insurance Assistance within 60 days.
8. COBRA and/or health insurance premium payments may be available for a limited time based on funds availability and proof that the client is applying for another payer source (AIPPS)
9. Individuals who receive a premium tax credit or plan to claim the premium tax credit must file a federal income tax return. Any excess premium tax credit a client receives is due back to the program.

IX. Mental Health Therapy/Counseling

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

Additional PCHAP guidelines:

1. Mental Health services will be billed at the current contracted rate using a unit of 15 minutes. (four 15-minute units = one hour)
2. Mental health services are limited to 52 hours per year, per client for individual or group counseling. The one-year period begins with the client's first visit.
3. Telehealth services for mental health are permitted.

X. Medical Transportation

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

1. Medical transportation may be provided through
 - a) Contracts with providers of transportation services,
 - b) Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established

- rates for federal programs (Federal Joint Travel Regulations provide further guidance on this subject),
- c) Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle,
 - d) Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed), and
 - e) Voucher or token systems.

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

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

Additional PCHAP guidelines:

- 4. All clients who meet the eligibility requirements must apply for the Medicaid pass for public transportation services. The distribution of bus passes to clients should be considered a last resort for the provision of transportation services.
- 5. Bus passes should only be provided to RW clients in need of accessing health care or psycho-social support services.
- 6. Use of taxis, Uber, Lyft, or any cash reimbursement transportation service is strictly prohibited, unless there is a State contract in place.

XI. Food Bank/Home Delivered Meals

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food.

- 1. When funding allows this also includes the provision of essential non-food items that are limited to the following:
 - a) Personal hygiene products
 - b) Household cleaning supplies
 - c) Water filtration/purification systems in communities where issues of water safety exist.

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

Additional PCHAP Guidelines:

3. RW clients who are currently retained in care are eligible to receive \$35 per month in food vouchers/coupons (subject to funds availability).

XII. Medical Nutrition Therapy

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 or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

1. Medical Nutrition Therapy Includes:

- a) Nutrition assessment and screening,
- b) Dietary/nutritional evaluation,
- c) Food and/or nutritional supplements per medical provider's recommendation, and
- d) Nutrition education and/or counseling.

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

Additional PCHAP guidelines:

3. An approved nutrition plan must be provided for the authorization of nutritional supplements. At a minimum the nutritional plan must include:

- a) Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food,
- b) Goals and desired outcomes developed in conjunction with the client and signed by the client,
- c) Date service is to be initiated,
- d) Planned number and frequency of sessions,
- e) Signature of the registered dietitian who developed the plan.