Houston Area HIV Services Ryan White Planning Council
Office of Support
Meeting Location: 1440 Harold Street, Houston, Texas 77006
832 927-7926 telephone; http://rwpchouston.org

Memorandum

To:	Members, Quality Improvement Committee	
	Tana Pradia, Co-Chair	Norman Mitchell
	Pete Rodriguez, Co- Chair	Diana Morgan
	Kevin Aloysius	Beatriz E.X. Rivera
	Yvonne Arizpe	Evelio Salinas Escamilla
	Caleb Brown	*Rodrigo Arias*
	Michael Elizabeth	*Lisa Felix*
	Glen Hollis	*Ivy Ortega*
	Denis Kelly	*Gloria Sierra*
		Mike Smith
Copy:	Glenn Urbach	Patrick Martin
	Eric James	Tionna Cobb
	Mauricia Chatman	Jeff Benavides
	Francisco Ruiz	Diane Beck
	Tiffany Shepherd	Rodriga "Rod" Avila
	Sha'Terra Johnson	Gary Grier
From:	Tori Williams	
Date:	Tuesday, September 10, 2024	
Re:	Meeting Notice	

Please join us for your next meeting, either virtually or in person. Details are as follows:

Quality Improvement Committee Meeting
2:00 p.m., Tuesday, September 17, 2024

To participate virtually, click on this link:
https://us02web.zoom.us/j/81144509622?pwd=SFNBM1RScVFabHkzakVpaUZoeHhIdz09
Meeting ID: 811 4450 9622 Passcode: 125672
Or, call in by dialing: 346 248 7799
To attend in person: Bering Church, 1440 Harold St, Houston, Texas 77006. Please enter the building from the Hawthorne Street parking lot behind the church.

RSVP to Rod and let her know if you will be in attendance and if it will be in person or virtually. Please rsvp even if you cannot attend the meeting. She can be reached at: Rodriga.Avila@harriscountytx.gov or by telephone at 832 927-7926. And, if you have questions for your committee mentor, do not hesitate to contact her at: Tana Pradia, 832 298-4248, tanapradia@gmail.com.

DRAFT

Houston Area HIV Services Ryan White Planning Council
Quality Improvement Committee
2:00 p.m., Tuesday, September 17, 2024

Join the meeting via Zoom:
https://us02web.zoom.us/j/81519929661?pwd=cXZPdzkzdjJwWnJPeFRJc1RwOStYUT09
Meeting ID: 811 4450 9622 Passcode: 125672

Or, use your cell phone to dial in at: 346 248 7799

To attend in person: Bering Church, 1440 Harold St, Houston, Texas 77006. Please enter the building from the Hawthorne Street parking lot behind the church.

Agenda

* = Handout to be distributed at the meeting

Please note that the use of artificial intelligence (AI) is prohibited at Ryan White sponsored meetings.

I. Call to Order — Tana Pradia and Pete Rodriguez, Co-Chair
   A. Welcoming Remarks and Moment of Reflection
   B. Adoption of Agenda
   C. Approval of Minutes

II. Public Comments and Announcements
(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing your self, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.

III. Old Business
   A. Reports from Part A/MAI Administrative Agency — Glenn Urban
      - Verbal Updates on Geriatric Case Management Services
   B. Reports from the Part B/SS Administrative Agency — Patrick Martin

IV. New Business
   A. Part B Standards of Care Review
      - Emergency Financial Assistance
      - LPAP
      - Medical Case Management
      - Non-Medical Case Management
      - Referral Health Care & Support Services

VI. Announcements

VII. Adjourn

Optional: New members meet with committee mentor — Tana Pradia

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, August 13, 2024
Meeting location: Bering Church 1440 Harold St, Houston, TX 77006 and Zoom Teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Tana Pradia, Co-Chair	Michael Elizabeth	Josh Mica, he/him/el, RWPC Chair
Pete Rodriguez, Co-Chair	Norman Mitchell	Georgina German, NA Interpreter
Kevin Aloysius	Diana Morgan	Steven Vargas, RWPC
Yvonne Arizpe	Oscar Perez	Adriana Dibello, AAMA, Inc.
Caleb Brown	*Lisa Felix*	Elia Chino, FLAS, Inc.
Evelio Salinas Escamilla	*Ivy Ortega*	Daniel Ramos, ViiV Healthcare
Glen Hollis	*Mike Smith*	Kimmy Palacios, FLAS, Inc.
Denis Kelly		Omar Toirac, FLAS, Inc.
Beatriz E.X. Rivera		Omar Navarro, FLAS, Inc.
Rodrigo Arias		Esmeralda Oregon, FLAS, Inc.
Gloria Sierra		Eric James, RWGA
		Mauricia Chatman, RWGA
		Frank Ruiz, RWGA
		Patrick Martin, TRG
		Tionna Cobb, TRG
		Sha'Terra Johnson, TRG
		Tori Williams, Ofc. of Support
		Diane Beck, Ofc. of Support

Call to Order: Pete Rodriguez, Co-Chair, called the meeting to order at 2:05 p.m. and asked for a moment of reflection.

Adoption of the Agenda: ***Motion #1****: it was moved and seconded (Escamilla, Kelly) to approve the agenda.* **Motion carried**.

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Escamilla, Kelly) to approve the July 25, 2024 minutes.* **Motion carried**. Abstentions: Brown, Escamilla.

Public Comment: See attached transcript.

Reports from the Administrative Agents:
Ryan White Part A/MAI: James said that he took notes from the public comment today and would take back to review with his colleagues at Ryan White Grant Administration. Spending is low on the procurement report for most service categories since they have been working on partial contracts. All services have now received full funding so we should see an increase in spending going forward. Service utilization is also a little behind due to the partial contracts so

we expect that will also pick up. Two categories have no data – Geriatric Case Management and Veteran Case Management. Geriatric services have just rolled out and while we have an active contract for veterans, those services are still being referred out. James presented the following reports, see attached:

- FY 2024 Part A/MAI Procurement Report, dated 08/05/2024
- FY 2024 Part A/MAI Service Utilization Report, dated 08/05/2024

Escamilla asked if viral suppression numbers could be included on the service utilization reports. Chatman said that Keizman used to provide this for the committee; she will work with Ruiz to have it for the next meeting. Rodriguez said it would be good to have the report on a quarterly basis.

Ryan White Part B and State Services: P. Martin said that the Standards of Care meetings would be a good place to address the public comment received today. P. Martin presented the following reports, see attached:

- FY2024-25 Part B Procurement Report, dated 07/31/2024
- FY2024-25 Part B Service Utilization Report, dated 07/25/2024
- FY2023-24 DSHS State Services Procurement Report, dated 07/31/24
- Health Insurance Service Utilization Report, dated 07/25/24

Texas Department of State Health Services Service Category Standards:
See attached DSHS service category standards for Emergency Financial Assistance, Local Pharmacy Assistance Program, Medical Case Management, Non-Medical Case Management, and Referral for Health Care and Support Services. Williams said that the committee will catch up on these standards of care in September and then review 2 in October and November and the last 6 of them in February. Please review the information and send your questions to her and she will contact DSHS to get someone to provide answers in advance or on Zoom at the meeting.

Announcements: Chatman said that the RWGA Clinical Quality Improvement Committee has been restructured and is convening quarterly meetings. One of the agenda items in this meeting is reviewing Performance Measure Data as an EMA and across agencies. RWGA welcomes a member of this committee to join the quarterly meetings. Sierra said that the next meeting of the Latino HIV Task Force is August 27 @ 2:00 PM at 3700 Buffalo Speedway in the Conference room of the building.

Adjourn: ***Motion:*** *it was moved and seconded (Kelly, Pradia) to adjourn the meeting at 3:20 p.m.* **Motion Carried.**

Submitted by: Approved by:

Tori Williams, Director Date Committee Chair Date

Scribe: Beck

ja = Just arrived at meeting
lm = Left the meeting
C = Chaired the meeting

2024 Quality Improvement Meeting Voting Record for Meeting Date 08/13/24

MEMBERS:	Motion #1 Agenda				Motion #2 Minutes			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Tana Pradia, Co-Chair		X				X		
Pete Rodriguez, Co- Chair				C				C
Kevin Aloysius		X				X		
Yvonne Arizpe ja 2:55 pm	X				X			
Caleb Brown		X						X
Michael Elizabeth	X				X			
Glen Hollis		X				X		
Denis Kelly		X				X		
Norman Mitchell	X				X			
Diana Morgan	X				X			
Oscar Perez	X				X			
Beatriz E.X. Rivera		X				X		
Evelio Salinas Escamilla		X						X
Lisa Felix	X				X			
Ivy Ortega	X				X			
Gloria Sierra		X				X		
Mike Smith	X				X			

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2024 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**11,169,413**	**370,766**	**134,765**	**0**	**0**	**0**	**11,674,944**	**46.32%**	**11,674,944**	**0**		**$3,055,659**	**26%**	**50%**
1.a	Primary Care - Public Clinic (a)	4,109,697	144,599					4,254,296	16.88%	4,254,296	0	3/1/2024	$1,099,651	26%	50%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,114,019	37,077	45,820				1,196,916	4.75%	1,196,916	0	3/1/2024	$420,118	35%	50%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	952,840	33,369	39,082				1,025,291	4.07%	1,025,291	0	3/1/2024	$459,701	45%	50%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,201,238	40,784	49,863				1,291,885	5.13%	1,291,885	0	3/1/2024	$239,107	19%	50%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,151,088	40,784					1,191,872	4.73%	1,191,872	0	3/1/2024	$191,585	16%	50%
1.f	Primary Care - Women at Public Clinic (a)	2,090,531	74,153					2,164,684	8.59%	2,164,684	0	3/1/2024	$418,192	19%	50%
1.g	Primary Care - Pediatric (a.1)														
1.h	Vision	500,000						500,000	1.98%	500,000	0	3/1/2024	$227,305	45%	50%
1.x	Primary Care Health Outcome Pilot	50,000	0					50,000	0.20%	50,000	0	3/1/2024	$0	0%	50%
2	**Medical Case Management**	**2,183,040**	**0**	**0**	**0**	**0**	**0**	**2,183,040**	**8.66%**	**2,183,040**	**0**		**395,404**	**18%**	**50%**
2.a	Clinical Case Management	531,025	0					531,025	2.11%	531,025	0	3/1/2024	$144,585	27%	50%
2.b	Med CM - Public Clinic (a)	301,129	0					301,129	1.19%	301,129	0	3/1/2024	$85,524	28%	50%
2.c	Med CM - Targeted to AA (a) (e)	183,663	0					183,663	0.73%	183,663	0	3/1/2024	$32,680	18%	50%
2.d	Med CM - Targeted to H/L (a) (e)	183,665	0					183,665	0.73%	183,665	0	3/1/2024	$16,139	9%	50%
2.e	Med CM - Targeted to W/MSM (a) (e)	66,491	0					66,491	0.26%	66,491	0	3/1/2024	$8,951	13%	50%
2.f	Med CM - Targeted to Rural (a)	297,496	0					297,496	1.18%	297,496	0	3/1/2024	$37,729	13%	50%
2.g	Med CM - Women at Public Clinic (a)	81,841	0					81,841	0.32%	81,841	0	3/1/2024	$53,506	65%	50%
2.h	Med CM - Targeted Geriatrics	400,899	0					400,899	1.59%	400,899	0	3/1/2024	$0	0%	0%
2.i	Med CM - Targeted to Veterans	86,964	0					86,964	0.35%	86,964	0	3/1/2024	$0	0%	50%
2.j	Med CM - Targeted to Youth	49,867	0					49,867	0.20%	49,867	0	3/1/2024	$16,290	33%	50%
3	**Local Pharmacy Assistance Program**	**2,067,104**	**0**	**33,513**	**0**	**0**	**0**	**2,100,617**	**8.33%**	**2,100,617**	**0**	3/1/2024	**$720,638**	**34%**	**50%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	367,104	0					367,104	1.46%	367,104	0	3/1/2024	$105,730	29%	50%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,700,000	0	33,513				1,733,513	6.88%	1,733,513	0	3/1/2024	$614,908	35%	50%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**0**	**166,404**	**0.66%**	**166,404**	**0**	3/1/2024	**66,550**	**40%**	**50%**
4.b	Oral Health - Targeted to Rural	166,404	0					166,404	0.66%	166,404	0	3/1/2024	$66,550	40%	50%
5	**Health Insurance (c)**	**1,583,137**		**311,204**	**0**	**0**	**0**	**1,894,341**	**7.52%**	**1,894,341**	**0**	3/1/2024	**$543,986**	**29%**	**50%**
7	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**					**341,395**	**1.35%**	**341,395**	**0**	3/1/2024	**$133,412**	**39%**	**50%**
8	**Substance Abuse Services - Outpatient (c)**	**25,000**	**0**	**0**	**0**	**0**	**0**	**25,000**	**0.10%**	**25,000**	**0**	3/1/2024	**$5,873**	**23%**	**50%**
10	**Emergency Financial Assistance**	**2,139,136**	**0**	**11,722**	**0**	**0**	**0**	**2,150,858**	**8.53%**	**2,150,858**	**0**		**$497,121**	**23%**	**50%**
10.a	EFA - Pharmacy Assistance	2,039,136	0	11,722				2,050,858	8.14%	2,050,858	0	3/1/2022	$478,309	23%	50%
10.b	EFA - Other	100,000	0					100,000	0.40%	100,000	0	3/1/2024	$18,811	19%	50%
12	**Non-Medical Case Management**	**1,267,002**	**0**	**0**	**0**	**0**	**0**	**1,267,002**	**5.03%**	**1,267,002**	**0**	3/1/2024	**$351,132**	**28%**	**50%**
12.a	Service Linkage targeted to Youth	110,793	0					110,793	**0.44%**	110,793	0	3/1/2024	$29,617	27%	50%
12.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0					100,000	**0.40%**	100,000	0	3/1/2024	$22,469	22%	50%
12.c	Service Linkage at Public Clinic (a)	370,000	0					370,000	**1.47%**	370,000	0	3/1/2024	$135,924	37%	50%
12.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209	0					686,209	**2.72%**	686,209	0	3/1/2024	$163,123	24%	50%
13	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**0**	**424,911**	**1.69%**	**424,911**	**0**		**$80,164**	**19%**	**50%**
13.a	Medical Transportation services targeted to Urban	252,680	0					252,680	1.00%	252,680	0	3/1/2024	$48,588	19%	50%
13.b	Medical Transportation services targeted to Rural	97,185	0					97,185	0.39%	97,185	0	3/1/2024	$31,576	32%	50%
13.c	Transportation vouchering (bus passes & gas cards)	75,046	0					75,046	0.30%	75,046	0	3/1/2024	$0	0%	50%
15	**Outreach**	**320,000**	0					**320,000**	**1.27%**	320,000	**0**	3/1/2024	**$42,467**	**13%**	**50%**
FY23_RW_DIR	**Total Service Dollars**	**21,686,542**	**370,766**	**491,204**	**0**	**0**	**0**	**22,548,512**	**89.46%**	**22,548,512**	**0**		**$5,892,404**	**26%**	**50%**
		24,342,152	**370,766**	**491,204**	**0**	**0**	**0**	**25,204,122**	**100.00%**	**25,204,122**	**0**		**$6,873,301**	**27%**	**50%**
									Unallocated	Unobligated					50%
	Part A Grant Award:	**25,204,121**	***Carryover:***	**491,204**			***Total Part A:***	**25,204,121**	**-1**	**0**					50%

		Original Allocation	Award Reconcilation	July Adjusments (carryover)	August 10% Rule Adjustments	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	Award Category	Award Amount	Amount Spent	Balance
	Core (must not be less than 75% of total service dollars)	**17,535,493**	**370,766**	**479,482**	**0**	**0**	**0**	**18,385,741**	**81.54%**	**4,377,535**	**82.50%**	Formula			0

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2024 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
	Non-Core (may not exceed 25% of total service dollars)	**4,151,049**	**0**	**11,722**	**0**	**0**	**0**	**4,162,771**	**18.46%**	**928,417**	**17.50%**	Supplement			0
	Total Service Dollars (does not include Admin and QM)	**21,686,542**	**370,766**	**491,204**	**0**	**0**	**0**	**22,548,512**		**5,305,952**		Carry Over	0		0
												Totals	0	0	0
	Total Admin (must be ≤ 10% of total Part A + MAI)	**2,125,040**	**0**	**0**	**0**	**0**	**0**	**2,125,040**	**7.68%**						
	Total QM (must be ≤ 5% of total Part A + MAI)	**530,570**	**0**	**0**	**0**	**0**	**0**	**530,570**	**1.92%**						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**2,068,055**	**30,356**	**47,459**	**0**	**0**	**0**	**2,145,870**	**87.07%**	**2,145,870**	**0**		**$766,265**	**36%**	**50%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,045,669	15,482	24,204	0			1,085,355	44.04%	1,085,355	0	3/1/2024	$424,005	39%	50%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	1,022,386	14,874	23,255	0			1,060,515	43.03%	1,060,515	0	3/1/2024	$342,260	32%	50%
2	**Medical Case Management**	**314,060**	**4,536**	**0**	**0**	**0**	**0**	**318,596**	**12.93%**	**318,596**	**0**		**$64,806**	**20%**	50%
2.c (MAI)	MCM - Targeted to African American	157,030	2,268					159,298	6.46%	159,298	0	3/1/2024	$43,019	27%	50%
2.d (MAI)	MCM - Targeted to Hispanic	157,030	2,268					159,298	6.46%	159,298	0	3/1/2024	$21,788	14%	50%
	Total MAI Service Funds	**2,382,115**	**34,892**	**47,459**	**0**	**0**	**0**	**2,464,466**	**100.00%**	**2,464,466**	**0**		**$831,071**	**34%**	**50%**
	Grant Administration	0	0	0	0	0	0	0	0.00%	0	0		$0	0%	0%
	Quality Management	0	0	0	0	0	0	0	0.00%	0	0		$0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**$0**	**0%**	**0%**
	Total MAI Funds	**2,382,115**	**34,892**	**47,459**	**0**	**0**	**0**	**2,464,466**	**100.00%**	**2,464,466**	**0**		**$831,071**	**34%**	**50%**
	MAI Grant Award	**2,464,466**	***Carry Over:***	**47,459**			***Total MAI:***	**2,464,466**							50%
	Combined Part A and MAI Orginial Allocation Total	**26,724,267**							Unallocated	Unobligated					
									0	**0**		***MAI Award***	**2,464,466**		
												Total Part A & MAI Award	**27,668,587**		

Footnotes:

All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.
(a)	Single local service definition is multiple HRSA service categories. (1) does not include LPAP. Expenditures must be evaluated both by individual service category and by combined service categories.
(c)	Funded under Part B and/or SS
(e)	10% rule reallocations

FY 2024 Ryan White Part A and MAI Service Utilization Report

Date Range: 03/01/2024 - 8/31/2024 23:59:00

RW PART A Service Utilization Report																		
Priority	**Service Category**	**Goal**	**Unduplicated Clients Served YTD**	**Male**	**Female**	**Trans gender**	**AA (non - Hispanic)**	**White (non -Hispanic)**	**Other (non - Hispanic)**	**Hispanic**	**0-12**	**13-19**	**20-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**9,780**	**5,193**	**74%**	**24%**	**2%**	**40%**	**12%**	**2%**	**46%**	**0%**	**0%**	**4%**	**26%**	**27%**	**23%**	**17%**	**3%**
1.a	Primary Care - Public Clinic (A)	3,113	2,083	69%	29%	1%	39%	7%	2%	52%	0%	0%	3%	17%	26%	27%	22%	5%
1.b	Primary Care - CBO Targeted to AA (A)	2,335	1,158	70%	27%	3%	99%	0%	1%	0%	0%	0%	6%	36%	27%	16%	12%	2%
1.c	Primary Care - CBO Targeted to Hispanic (A)	1,934	1,168	81%	15%	4%	0%	0%	0%	100%	0%	1%	5%	31%	29%	22%	10%	2%
1.d	Primary Care - CBO Targeted to White and/or MSM (A)	774	470	85%	13%	2%	0%	83%	17%	0%	0%	0%	3%	25%	26%	24%	20%	3%
1.e	Primary Care - CBO Targeted to Rural (A)	752	360	70%	29%	1%	38%	20%	2%	40%	0%	0%	5%	25%	29%	25%	14%	2%
1.f	Primary Care - Women at Public Clinic (A)	872	614	0%	99%	1%	49%	4%	1%	45%	0%	0%	2%	13%	28%	29%	22%	6%
1.g	Primary Care - Pediatric (A)																	
1.h	**Vision**	**2,663**	**1,239**	**71%**	**26%**	**2%**	**46%**	**11%**	**3%**	**40%**	**0%**	**0%**	**3%**	**22%**	**25%**	**25%**	**19%**	**5%**
2	**Medical Case Management**	**5,719**	**1,436**	**66%**	**31%**	**3%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
2.a	Clinical Case Management	967	297	72%	25%	3%	56%	17%	1%	27%	0%	0%	2%	21%	21%	21%	26%	9%
2.b	Med CM - Targeted to Public Clinic (A)	578	301	90%	7%	3%	52%	12%	1%	35%	0%	1%	1%	28%	25%	19%	22%	4%
2.c	Med CM - Targeted to AA (A)	1,479	259	65%	28%	7%	97%	1%	1%	2%	0%	1%	4%	34%	31%	17%	11%	3%
2.d	Med CM - Targeted to H/L (A)	728	137	83%	12%	5%	0%	0%	0%	100%	0%	0%	5%	31%	29%	22%	11%	2%
2.e	Med CM - Targeted to White and/or MSM (A)	460	54	81%	19%	0%	0%	93%	7%	0%	0%	0%	2%	22%	20%	30%	19%	7%
2.f	Med CM - Targeted to Rural (A)	554	205	62%	38%	0%	55%	23%	1%	20%	0%	0%	2%	16%	21%	24%	26%	10%
2.g	Med CM - Targeted to Women at Public Clinic (A)	259	178	1%	99%	0%	69%	6%	1%	25%	0%	0%	1%	26%	30%	24%	14%	4%
2.h	Med CM - Targeted to Geriatrics	532																
2.i	Med CM - Targeted to Veterans	148																
2.j	Med CM - Targeted to Youth	14	5	100%	0%	0%	40%	0%	0%	60%	0%	40%	60%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (A)**	**5,781**	**3,501**	**74%**	**22%**	**3%**	**40%**	**11%**	**2%**	**47%**	**0%**	**0%**	**3%**	**23%**	**27%**	**26%**	**17%**	**3%**
4	**Oral Health**	**348**	**216**	**67%**	**32%**	**0%**	**39%**	**29%**	**2%**	**30%**	**0%**	**0%**	**0%**	**17%**	**28%**	**29%**	**15%**	**11%**
4.a	Oral Health - Untargeted (D)	NA	NA															
4.b	Oral Health - Rural Target	348	216	67%	32%	0%	39%	29%	2%	30%	0%	0%	0%	17%	28%	29%	15%	11%
5	**Health Insurance (D)**	**2,034**	**1,316**	**78%**	**20%**	**2%**	**43%**	**21%**	**3%**	**33%**	**0%**	**0%**	**2%**	**13%**	**22%**	**22%**	**29%**	**12%**

6	**Mental Health Services (D)**	**NA**	**NA**															
7	**Medical Nutritional Therapy/Nutritional Supplements**	**515**	**301**	**76%**	**22%**	**2%**	**41%**	**17%**	**5%**	**38%**	**0%**	**0%**	**1%**	**7%**	**9%**	**28%**	**36%**	**20%**
8	**Substance Abuse Treatment - Outpatient**	**19**	**7**	**100%**	**0%**	**0%**	**14%**	**29%**	**0%**	**57%**	**0%**	**0%**	**0%**	**43%**	**43%**	**0%**	**14%**	**0%**
9	**Hospice Services**	**NA**	**NA**															
10	**Emergency Financial Assistance**	**3,218**	**594**	**75%**	**23%**	**2%**	**44%**	**9%**	**2%**	**45%**	**0%**	**1%**	**5%**	**21%**	**30%**	**24%**	**18%**	**2%**
10.a	Emergency Financial Assistance-Pharmacy Assistance	3,105	527	75%	23%	2%	42%	9%	2%	48%	0%	1%	5%	21%	31%	24%	16%	2%
10.b	Emergency Financial Assistance - Other (MCC only)	113	67	72%	25%	3%	58%	13%	0%	28%	0%	0%	4%	19%	16%	18%	33%	9%
11	**Referral for Health Care - Non Core Service (D)**	**NA**	**NA**															
12	**Non-Medical Case Management**	**8,568**	**3,426**															
12.a	Service Linkage Targeted to Youth	179	128	63%	32%	5%	55%	2%	2%	40%	0%	10%	90%	0%	0%	0%	0%	0%
12.b	Service Linkage at Testing Sites	132	55	71%	25%	4%	53%	2%	5%	40%	0%	0%	0%	62%	25%	5%	5%	2%
12.c	Service Linkage at Public Clinic Primary Care Program (A)	3,621	1,959	64%	35%	1%	49%	8%	2%	42%	0%	0%	0%	17%	26%	26%	24%	7%
12.d	Service Linkage at CBO Primary Care Programs (A)	4,636	1,284	71%	25%	4%	45%	9%	2%	44%	0%	1%	4%	28%	28%	21%	14%	4%
13	**Transportation**	**2,358**	**855**	**71%**	**27%**	**2%**	**61%**	**9%**	**2%**	**28%**	**0%**	**0%**	**1%**	**15%**	**21%**	**26%**	**29%**	**8%**
13.a	Transportation Services - Urban	687	185	63%	35%	2%	51%	9%	5%	35%	0%	1%	1%	19%	24%	24%	21%	10%
13.b	Transportation Services - Rural	195	69	64%	35%	1%	30%	36%	1%	32%	0%	0%	1%	14%	16%	33%	23%	12%
13.c	Transportation vouchering	1,476	678	72%	26%	2%	67%	6%	1%	25%	0%	0%	1%	13%	19%	27%	32%	8%
14	**Linguistic Services (D)**	**NA**	**NA**															
15	**Outreach Services**	**955**	**266**	**68%**	**29%**	**3%**	**64%**	**9%**	**2%**	**26%**	**0%**	**0%**	**6%**	**36%**	**26%**	**16%**	**12%**	**3%**
	Net unduplicated clients served - all categories	**15,378**	**10,332**	**73%**	**25%**	**2%**	**45%**	**12%**	**2%**	**40%**	**0%**	**0%**	**4%**	**23%**	**25%**	**23%**	**19%**	**6%**
	Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (B)	**NA**	**30,198**	**75%**	**25%**	**0%**	**48%**	**17%**	**5%**	**30%**	**0%**		**4%**	**21%**	**23%**	**25%**	**20%**	**0%**

RW MAI Service Utilization Report

Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans gender	AA (non - Hispanic)	White (non - Hispanic)	Other (non - Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-54	55-64	65+
	Outpatient/Ambulatory Primary Care (excluding Vision)	**3,129**																
1.b	Primary Care - MAI CBO Targeted to AA (F)	1,676	1,074	71%	26%	3%	100%	0%	0%	0%	0%	0%	5%	36%	28%	16%	11%	3%
1.c	Primary Care - MAI CBO Targeted to HL (F)	1,453	900	82%	14%	3%	0%	0%	0%	100%	0%	0%	4%	32%	28%	22%	10%	2%
2	**Medical Case Management (E)**	**1,535**																
2.c	Med CM - MAI Targeted to AA (A)	907	171	64%	31%	5%	100%	0%	0%	0%	0%	1%	2%	43%	29%	12%	11%	2%
2.d	Med CM - MAI Targeted to H/L (A)	628	90	73%	19%	8%	0%	0%	0%	100%	0%	0%	6%	37%	29%	18%	9%	2%

RW Part A New Client Service Utilization Report
Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months

Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans gender	AA (non - Hispanic)	White (non -Hispanic)	Other (non - Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-54	55-64	65+
1	**Primary Medical Care**	**1,929**	**749**	**75%**	**22%**	**3%**	**50%**	**12%**	**1%**	**36%**	**0%**	**1%**	**8%**	**36%**	**26%**	**15%**	**11%**	**3%**
2	**LPAP**	**969**	**289**	**78%**	**17%**	**4%**	**43%**	**11%**	**1%**	**45%**	**0%**	**1%**	**8%**	**34%**	**25%**	**17%**	**14%**	**2%**
3.a	**Clinical Case Management**	**110**	17	82%	12%	6%	59%	18%	0%	24%	0%	0%	12%	24%	35%	6%	18%	6%
3.b-3.h	**Medical Case Management (E)**	**1,050**	235	69%	30%	2%	58%	11%	1%	31%	0%	2%	4%	33%	26%	20%	14%	2%
3.i	**Medical Case Manangement - Targeted to Veterans**	**28**																
4	**Oral Health**	**49**	**6**	**83%**	**17%**	**0%**	**67%**	**33%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**17%**	**33%**	**17%**	**33%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**1,981**	618	67%	31%	2%	57%	8%	2%	33%	0%	1%	7%	25%	25%	20%	18%	6%
12.b	**Service Linkage at Testing Sites**	**100**	50	66%	30%	4%	56%	2%	6%	36%	0%	4%	14%	50%	20%	4%	6%	2%

FOOTNOTES
(A) Bundled Category
(B) Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
(D) Funded by Part B and/or State Services
(E) Total MCM served does not include Clinical Case Management
(F) CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2425 Ryan White Part B

Procurement Report

April 1, 2024 - March 31, 2025

Reflects spending through July 2024

Spending Target: 33%

Revised 9/5/24

Priority	Service Category	Original Allocation per	% of Grant	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original	Expended YTD	Percent YTD
4	Oral Health Service-General	$2,101,048	59%		$2,101,048		$2,101,048	4/1/2023	$453,889	22%
4	Oral Health Service -Prosthodontics	$631,145	18%		$631,145		$631,145	4/1/2023	$216,297	34%
5	Health Insurance Premiums and Cost Sharing (1)	$805,845	23%		$805,845		$805,845	4/1/2023	$780,542	97%
				$0	$0		$0			
		$0	0%	$0	$0					
	Total Houston HSDA	3,538,038	100%	0	3,538,038	$0	$3,538,038		1,450,729	41%

Note: Spending variances of 10% of target will be addressed:

(1) Increase due to costs in spending

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2324 DSHS State Services

Procurement Report

September 1, 2023 - August 31, 2024

Chart reflects spending through July 2024

Spending Target: 91.67%

Revised 9/5/2024

Priority	Service Category	Original Allocation per	% of Grant	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$892,101	29%	$141,000	$1,033,101	$0	$1,033,101	9/1/2023	$1,231,373	119%
6	**Mental Health Services (5)**	$300,000	10%	$0	$300,000	$0	$300,000	9/1/2023	$179,878	60%
11	**Hospice**	$293,832	10%	$57,388	$351,220	$0	$351,220	9/1/2023	$243,100	69%
13	**Non Medical Case Management (2)**	$350,000	12%	-$57,388	$292,612	$0	$292,612	9/1/2023	$121,298	41%
16	**Linguistic Services (3)**	$68,000	2%	$0	$68,000	$0	$68,000	9/1/2023	$8,774	13%
	Referral for Healthcare-Incarcerated (6)	$141,000	5%	-$141,000	$0	$0	$0	9/1/2023	$0	0%
	ADAP/Referral for Healthcare (4)	$525,000	17%	$0	$525,000	$0	$525,000	9/1/2023	$389,081	74%
	Food Bank	$5,400	0.2%	$0	$5,400	$0	$5,400	9/1/2023	$2,378	44%
	Medical Transportation	$84,600	3%	$0	$84,600	$0	$84,600	9/1/2023	$53,126	63%
	Emergency Financial Assistance (Compassionate Care)	$368,123	12%	$0	$368,123	$0	$368,123	9/1/2023	$182,809	50%
		3,028,056	**100%**	**$0**	$3,028,056	$0	$3,028,056		2,411,817	80%

Note

(1) HIP- Funded by Part A, B and State Services/. Provider spends grant funds by ending dates Part A -2/28; B-3/31;SS-8/31.
(2) Reallocation approved due to a change in provider.
(3) Delayed billing
(4) Delayed billing
(5) Delayed billing
(6) Service was eliminated; reallocation approved by RWPC

Emergency Financial Assistance Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Food	Per visit
Housing	Per transaction
Medication	Per transaction
Other Allowable Healthcare Cost	Per transaction
Utilities	Per transaction

Health Resources and Service Administration (HRSA) Description:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist a Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by the Texas HIV Medication Program (the AIDS Drug Assistance Program for the State of Texas) or Local Pharmaceutical Assistance Program (LPAP), or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency financial assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

Agencies use other sources of funding in the community effectively, and any allocation of RWHAP funds for these purposes is the payer-of-last resort. RWHAP provides EFA to individual clients with a limited frequency and for a limited period of time, with a specified frequency and duration of assistance. Staff must document the emergent need each time agencies use EFA funds.

Limitations:

HRSA does not permit direct cash payments to clients. Agencies cannot fund the continuous provision of an allowable service to a client through EFA.

EFA services have an $800 per client per calendar year cap, with the following exceptions:

- The $800 per client per calendar year cap does not include medications purchased during the Texas HIV Medication Program (THMP) eligibility determination period; and
- Administrative agencies may approve a one-time waiver for a service exceeding the $800 per client per calendar year cap.

Agencies may only use EFA for short-term assistance with medications not covered by medical insurance:

- Agencies use the Local Pharmaceutical Assistance Program (LPAP) service category to provide long-term assistance with medications.
- Agencies use the Health Insurance Premium and Cost-Sharing Assistance service category to provide co-payment assistance for medications covered by insurance.

Services:

Agencies may use EFA funds on the following essential items or services:

- Medication not covered by THMP or LPAP, such as temporary access to THMP-eligible medications during the eligibility determination period
  - Agencies assist clients with applications for pharmaceutical company patient assistance programs to reduce the need or length of time for EFA assistance.
- Utilities (including gas, electricity, propane, water, internet, telephone services, and all required fees)
  - Agencies demonstrate that other private, local, and state utility assistance programs cannot meet the urgent need.
- Housing (which may include rent or temporary shelter)
  - Agencies only use EFA if comparable (Housing Opportunities for Persons with AIDS) HOPWA or Ryan White Housing Services assistance is not

available or if the client is not eligible for HOPWA or Housing Services.

  - Food (groceries or food vouchers) agencies demonstrate a lack of available food assistance programs or food bank services available to clients.

- Transportation
  - Agencies may not use Ryan White funds for direct maintenance expenses, or other costs associated with privately owned vehicles, such as lease or loan payments, insurance, or license and registration fees
- Prescription medication assistance such as:
  - Short-term, 30-day assistance for medication (clients can request an additional 30-day supply for a total of 60 days)
  - Medication administered on a one-time or occasional basis during a primary medical visit
- Medication dispensing fees associated with purchased medications[1]
- Other RWHAP allowable costs needed to improve health outcomes

Universal Standards:

Service providers for Emergency Financial Assistance must follow HRSA and DSHS Universal Standards 1-## and ###-###.

[1] Pharmacies under the 2017 or later Memorandum of Agreement do not collect a dispensing fee from clients. The pharmacy invoices the THMP directly each month for dispensed THMP medications, not to exceed $5.00 per medication. This includes Medicaid-eligible and non-eligible clients. See Texas HIV Medication Program Participating Pharmacy Guidelines.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Client Determination for Emergency Financial Assistance: Agencies maintain documentation of an urgent need for essential items or services necessary to improve health outcomes. Clients may demonstrate need by, but not limited to, the following: • A recent decrease in income or significant increase in bills; • High unexpected expenses on essential items; • The client cannot provide for basic needs or shelter; • A failure to provide EFA results in danger to the physical health of the client or dependent children; or • Other emergency needs as deemed appropriate by the agency. Agencies document other resources pursued prior to using EFA funding for assistance. If no other resources are available for the client's needs (e.g., a generic medication with no available patient assistance program), staff should note this in the client file.	1. Percentage of clients with documentation of urgent needs. 2. Percentage of clients with documentation of other resources pursued.

Assisting Client with Short-Term Medication: Agencies may provide short-term medication assistance (up to a 30-day supply at a time) with limited use of EFA for no more than 60 days total (two months or less) for RWHAP-eligible clients with documentation of an urgent need for HIV medications. • Agencies may assist clients with medications on the THMP formulary during the THMP eligibility determination period. The $800 per client per calendar year cap does not include medications purchased during the THMP eligibility determination period. • Agencies may provide other short-term medication assistance through EFA for RWHAP-eligible clients, including those with documentation of pending health insurance medication plan approval.	3. Percentage of clients with documentation of short-term medication assistance provided by amount, frequency, duration of assistance, and method.
Assisting Clients with Other Essential Services: Utilities, housing, food (including groceries and food vouchers), transportation, or other allowable healthcare costs.	4. Percentage of clients with documentation of non-medication related essential services by amount, frequency, duration of assistance, and method.

EFA Cap Waivers: In cases of emergency needs exceeding $800 per client per calendar year, providers must document the reason for exceeding the yearly maximum amount and must have documented approval of a one-time waiver from the local administrative agency (AA). This cap does not include medications purchased during the Texas HIV Medication Program (THMP) eligibility determination period.	5. Not including medications purchased during the THMP eligibility determination period, percentage of clients with documentation of a waiver approved by the AA, if the total amount of EFA exceeds the $800 per client per calendar year cap. (Pilot Measure 2024-2025)

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2023.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources and Services Administration, 22 Oct. 2018.

Texas Department of State Health Services. Texas HIV Medication Program Participating Pharmacy Guidelines, Last Updated: May 1, 2019.

Location of Change	Prior Version	New Version	Notes
Program Guidance Sections		Agencies will use other sources of funding in the community effectively and any allocation of RWHAP funds for these purposes will be as the payer-of-last-resort. EFA to individual clients is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Staff must document emergent need each time funds are used.	Language in this section was rearranged to simplify. Unclear language was removed. Paragraph 2 was removed to align with HRSA PCN 16-02. (Note: The NMS and US address the need to track categories for EFA.)
Limitations section	Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through EFA. EFA services have an $800 per client per calendar year cap, with the following exceptions: • The $800 per client per calendar year cap does not include medications purchased during the ADAP eligibility determination period. • The $800 per client per calendar year cap does not include medication dispensing fees. • Administrative Agencies may approve a one-time waiver for a service that exceeds the $800 per client per calendar year cap.	Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through EFA. EFA services have an $800 per client per calendar year cap, with the following exceptions: •The $800 per client per calendar year cap does not include medications purchased during the Texas HIV Medication Program (THMP) eligibility determination period. •Administrative Agencies may approve a one-time waiver for a service that exceeds the $800 per client per calendar year cap. EFA may only be used for short-term assistance with medications not covered by medical insurance: •Agencies will use the Local Pharmaceutical Assistance Program (LPAP) service category to provide long-term assistance with medications. •Agencies will use the Health Insurance Premium and Cost-Sharing Assistance service category to provide co-payment assistance for medications covered by insurance.	Bullet 2: Removed. Contracted pharmacies should directly bill THMP dispensing fees directly billed to THMP. Because of this, there is no reason to exclude dispensing fees from the $800 cap. Dispensing fees themselves are listed as an allowable expense below. Added: Para. "EFA may only be used for short-term assistance with medications not covered by medical insurance..." and bullets.

Services Section	EFA funds may be used on the following essential items or services: • Temporary access to ADAP-eligible medications during the ADAP eligibility determination period • Utilities (may include household utilities such as gas, electricity, propane, water, and all required fees) • Housing (may include as rent or temporary shelter) 4 Agencies can only use EFA if comparable HOPWA (Housing Opportunities for Persons With AIDS) or Ryan White (RW) housing assistance is not available or if the client is not eligible for HOPWA or RW housing services • Food (groceries or food vouchers) • Transportation • Prescription medication assistance such as short-term, one-time assistance for any medication as a result or component of a primary medical visit (not to exceed a 30-day supply) • Medication dispensing fees associated with purchased medications • Other RWHAP allowable costs needed to improve health outcomes	EFA funds may be used on the following essential items or services: ●Medication not covered by THMP or LPAP, such as temporary access to THMP-eligible medications during the eligibility determination period - Agencies will assist clients with applications for pharmaceutical company patient assistance programs to reduce the need or length of time EFA assistance is provided. ●Utilities (including gas, electricity, propane, water, internet, telephone services, and all required fees) - Agencies will demonstrate that other private, local, and state utility assistance programs are unable to meet the urgent need. ●Housing (may include rent or temporary shelter) - Agencies will only use EFA if comparable HOPWA (Housing Opportunities for Persons With AIDS) or Ryan White Housing Services assistance is not available or if the client is not eligible for HOPWA or Housing Services. - Food (groceries or food vouchers)Agencies will demonstrate a lack of available food assistance programs or food bank services available to clients. ●Transportation - Ryan White funds may not be used for direct maintenance expenses or any other costs associated with privately owned vehicles, such as lease or loan payments, insurance, or license and registration fees. ●Prescription medication assistance such as: - Short-term, 30-day assistance for any medication (An additional 30-day supply can be requested for a total of 60 days). -Medication administered on a one-time or occasional basis during a primary medical visit ●Medication dispensing fees associated with purchased medications ●Other RWHAP allowable costs needed to improve health outcomes	Utilities bullet: Added internet and telephone services as examples. Reason: People may not realize that those are allowable and both can be very important for clients to remain in care. Transportation bullet: Language expanded to reference disallowed transportation costs. Prescription medication bullet: Language edited for clarity." As a result of component of a primary medical visit" changed to "administered on a one-time or occasional basis during a primary medical visit" for clarity and to align with language proposed in LPAP service standard.

Client Determination for Emergency Financial Assistance Section	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, 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 or shelter • A failure to provide EFA will result in danger to the physical health of the client or dependent children • Other emergency needs as deemed appropriate by the agency Agency staff will conduct an assessment of the presenting needs of the client with the emergency financial issue. A service plan will be developed documenting the client's emergent need resulting in their inability to pay bills or prescriptions without assistance, and other resources pursued noted prior to using EFA funding for assistance. Measure 3. Percentage of clients with documentation of determination of EFA needs. Measure 4. Percentage of clients with documentation of a service plan for EFA that indicates the emergent need, other resources pursued, and outcome of EFA provided. Measure 5. Percentage of clients with documentation of resolution of the emergency status and referrals made (as applicable) with outcome results. Measure 6. Percentage of clients with documentation of a waiver approved by the Administrative Agency, if the total amount of EFA exceeds the $800 per client per calendar year cap. (Pilot Measure 2024-2025)	Agencies will maintain documentation of an urgent need for essential items or services necessary to improve health outcomes. Need may be demonstrated by, but not limited to, the following: • A recent decrease in income or significant increase in bills • High unexpected expenses on essential items • Client is unable to provide for basic needs or shelter • A failure to provide EFA will result in danger to the physical health of the client or dependent children • Other emergency needs as deemed appropriate by the agency Agencies will document other resources pursued prior to using EFA funding for assistance. If no other resources are available for the client's need (e.g., a generic medication with no available patient assistance program), staff will note this in the client file. Measure: Percentage of clients with documentation of urgent need. Percentage of clients with documentation of other resources pursued.	This section was rearranged and language simplified. Final 2 paragraphs replaced with language referencing documentation of other resources pursued. Standard: Language edited for clarity. Final 2 paragraphs replaced with language referencing documentation of other resources pursued. Measure 3: Changed language from ""EFA needs"" to "urgent need"". Measure 4, 5 were combined to simplify and avoid redundancy. Measure 6 was edited for clarity and moved to Assisting Client with Short-Term Medication section.

Assisting Clients during ADAP Eligibility Determination Period and Assisting Clients with Short-Term Medications Sections	**Assisting Clients during ADAP Eligibility Determination Period**: Agencies may provide short-term medication assistance (30-day supply) with limited use of EFA for no more than 60 days (two months or less) for RWHAP-eligible clients with documentation of an emergency need for HIV medications. **Assisting Clients with Short-Term Medications:** Agencies may provide short-term HIV medication assistance through EFA for RWHAP-eligible clients with documentation of pending health insurance medication plan approval. Measure: 1. Percentage of clients with documentation of short-term HIV medication assistance provided during the ADAP application period. 2. Percentage of clients with documentation of short-term HIV medication assistance provided during the health insurance application period.	**Assisting Client with Short Term Medication:** Agencies may provide short-term medication assistance (up to a 30-day supply at a time) with limited use of EFA for no more than 60 days total (two months or less) for RWHAP-eligible clients with documentation of an urgent need for HIV medications. •Agencies may assist clients with medications on the THMP formulary during the THMP eligibility determination period. The $800 per client per calendar year cap does not include medications purchased during the THMP eligibility determination period. •Agencies may provide other short-term medication assistance through EFA for RWHAP-eligible clients, including those with documentation of pending health insurance medication plan approval.	Paragraph was edited for clarity and to address potentially confusing "30-day supply" limit and the "no more than 60 days" limit. Language clarified to specify that only a 30-day fill may be covered (not a 90-day fill for example), and that this may be done twice for a total of 2 months. Moved language regarding THMP eligibility period assistance to this section. THMP eligibility period assistance is essentially a special case of short-term medication assistance. The time limit for assistance applies to both cases. Paragraph 2 was edited to combine this section with Short Term Medication section. Measure 1: Language edited to apply to all uses of EFA for medication assistance and check for uses of short-term duration. Measure 2: Measure was edited and moved to this section from Client Determination for Emergency Financial Assistance section.

Assisting Clients with Other Essential Services Section	None	Utilities, Housing, Food (including groceries and food vouchers), transportation, or other allowable healthcare costs. Measure 4: Percentage of clients with documentation of non-medication related essential services by amount, frequency, duration of assistance, and method.	New Standard and Measure added to provide for essential, non-medication services.
EFA Cap Waivers Section	None	In the cases of emergency need exceeding $800 per client per calendar year, providers are required to document the reason for exceeding the yearly maximum amount and must have documented approval of a one-time waiver from the local Administrative Agency (AA). This cap does not include medications purchased during the Texas HIV Medication Program (THMP) eligibility determination period. Measure 5: Not including medications purchased during the THMP eligibility determination period, percentage of clients with documentation of a waiver approved by the Administrative Agency, if the total amount of EFA exceeds the $800 per client per calendar year cap. (Pilot Measure 2024-2025)	New Standard and Measure added to ensure EFA in excess of the CAP meets requirements.

Local Pharmaceutical Assistance Program Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Local Pharmaceutical Assistance Program	Per prescription

Health Resources and Services Administration (HRSA) Description:

HRSA Ryan White HIV/AIDS Program (RWHAP) Part B recipients or subrecipients operate a Local Pharmaceutical Assistance Program (LPAP) as a supplemental means of providing ongoing medication assistance when a HRSA RWHAP AIDS Drug Assistance Program (ADAP) has a restricted formulary, waiting list, or restricted financial eligibility criteria.

Program Guidance:

An LPAP is a program to ensure that clients receive medications when other means to procure them are unavailable or insufficient. As such, LPAPs serve as an ongoing means of providing medications. Grant recipients may use the RWHAP Part B Base Award or Part A grant funds to support an LPAP.

Providers may use the funding to assist eligible clients with purchasing medications that exceed their Medicaid monthly allotment and that the THMP formulary does not cover.

Providers cannot use LPAP funds for emergency or short-term financial assistance. The Emergency Financial Assistance service category may provide short-term assistance for medications.

To maintain confidentiality, all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards.

Limitations:

Limitations on the use of LPAP include:

- LPAPs must not take the place of the ADAP program or duplicate services available through the Texas HIV Medication Program (THMP).
  - Clients currently eligible for THMP may only receive assistance with medications not on the THMP formulary.
  - Clients may not receive LPAP while awaiting a THMP eligibility determination. Agencies may use Emergency Financial Assistance (EFA) to provide services during the eligibility determination period.
- Providers must first use pharmaceutical assistance programs (PAPs) before using LPAP, and service providers cannot enroll clients in another medication assistance program for the same medication, excluding co-payment discounts.
- Agencies may not use funds to make direct cash payments to clients.
- All medications purchased with LPAP funds must be FDA-approved, consistent with the most current HHS HIV/AIDS Treatment Guidelines, and on the LPAP formulary.
  - Providers wishing to prescribe a medication not on the formulary shall make a request to the LPAP Board for approval to add the medication to the formulary. Providers may only purchase the medication after the LPAP board has added it to the formulary. For more information on medication formulary requirements, please review the LPAP Statement of Need.
- Agencies may not impose any charges on clients with incomes below 100 percent of the Federal Poverty Level (FPL).

  Clients with insurance and other third-party payer sources are not eligible for LPAP assistance unless there is documentation on file that their prescription benefits do not cover the medication.
- For the following services, agencies should use EFA instead of LPAP:
  - A result or component of a primary medical visit
  - A single occurrence of short duration (an emergency)
  - Vouchers for clients on a single occasion

Services:

RWHAP recipients using the LPAP service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A record-keeping system for distributed medications
- An LPAP advisory board
- A drug formulary that:
  - The local advisory committee approved
  - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility, with rescreening at a minimum every six months
- Coordination with the State's RWHAP Part B ADAP (a statement of need should specify restrictions of the state ADAP and the need for the LPAP)
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program and the Prime Vendor Program

Recipients may use LPAP funds to purchase prescribed over-the-counter (OTC) medications if the medication is on the LPAP formulary and the provider deems that the medication necessary for the prevention and treatment of opportunistic infections or to prevent the serious deterioration of health. OTC medications purchased with LPAP funds must be FDA-approved.

Universal Standards:

Services providers for Local Pharmaceutical Assistance Program Services must follow HRSA and DSHS Universal Standards 1-52 and 61-70.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Enrollment: Agencies must screen clients for THMP eligibility prior to enrollment in LPAP services and conduct rescreening every six months, at a minimum. Clients may not receive LPAP services while awaiting a THMP eligibility determination, although they may receive EFA during that time. Providers must also assist clients with enrollment in any applicable PAPs before using LPAP. Enrollment documentation must include documentation of the ongoing need for LPAP assistance. Client files must not indicate that services are being provided for a short duration, on an emergency basis, or as a component of a primary medical visit.	1. Percentage of client charts with enrollment documentation that includes: 1a. Screening for THMP eligibility at the time of enrollment or within the six months prior to enrollment. 1b. Rescreening for THMP eligibility every six months at a minimum. 1c. Documentation that clients were enrolled in any applicable PAPs. 2. Percentage of clients with documentation of an ongoing need for LPAP assistance.
LPAP Prescriptions: 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 the prescribing medical provider	3. Percentage of client charts with prescriptions for all medications provided through LPAP. 4. Percentage of client charts with documentation that all medications provided are on the LPAP formulary.

Timeliness of Service: LPAP programs should approve and ensure the availability of new prescriptions that meet the LPAP eligibility criteria within two business days.	5. Percentage of clients accessing services under LPAP who have access to their prescribed medication(s) within two business days of approved LPAP funding.
Prescribed Over the Counter (OTC) Medications: LPAP can assist clients with OTC medications if the provider prescribed the medication and deemed the medication necessary for the prevention and treatment of opportunistic infections or to prevent the serious deterioration of the client's health. OTC medication must be on the LPAP formulary.	6. Percentage of client files with prescribed OTC medications paid through LPAP funding with documentation of: (Pilot Measure) 6a. Medical necessity from the prescribing provider 6b. Linked to HIV or HIV-related conditions

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2023.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, 22 Oct. 2018.

Ryan White HIV/AIDS Program. Local Pharmaceutical Assistance Program (LPAP) FAQs · LPAP Policy Clarification Memo (8/29/13). Available at: https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/lpap-letter.pdf

Texas Administrative Code: TAC 22, Chapter 15, 291.6. Available at: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=15&ch=291&rl=6

Texas Department of State Health Services HIV/STD Program Policies. Payer of Last Resort (Policy 590.001). Available at: https://www.dshs.texas.gov/hivstd/policy/policies.shtm

Texas Department of State Health Services HIV/STD Program Policies HIV/STD Medication Program Pharmacy Eligibility Criteria. (Policy 700.003). Available at: https://www.dshs.texas.gov/hivstd/policy/policies.shtm

LPAP crosswalk - 08-13-24

Location of change	Prior Version	New Version	Notes
Enrollment section	None	1.Percentage of client charts with enrollment documentation that includes: 1a. Screening for THMP eligibility at the time of enrollment or within the six months prior to enrollment. 1b. Rescreening for THMP eligibility every six months at a minimum. 1c. Documentation that clients were enrolled in any applicable PAPs.	This measures compliance with the HRSA National Monitoring Standards and payor of last resort policy.
Enrollment section	None	2.Percentage of clients with documentation of ongoing need for LPAP assistance.	This measures compliance with the HRSA National Monitoring Standards and ensures LPAP category is used appropriately. For one-time or emergency assistance, the Emergency Financial Assistance category should be used.
LPAP Prescriptions section	1. Percentage of client charts that have the documented prescriptions funded through LPAP assistance with: 1a. Name of the client 1b. Date of birth 1c. Name of medication, dose, and signature of the prescribing medical provider.	3.Percentage of client charts with prescriptions for all medications provided through LPAP.	This measure was simplified to reduce monitoring burden. For a prescription to be filled by a pharmacy, it will need the name, date of birth, and full medication information; we do not need to individually monitor these elements.

LPAP crosswalk - 08-13-24

Location of change	Prior Version	New Version	Notes
LPAP Prescriptions section	None	4.Percentage of client charts with documentation that all medications provided are on the LPAP formulary.	This measures compliance with HRSA National Monitoring Standards and with the formulary system. Previously this was only being monitored for over-the-counter (OTC) prescriptions but will be required for all prescriptions.
Medication Adherence Counseling section	4. Percentage of clients who have documentation of having been offered adherence counseling when assistance is requested.	Entire section has been removed.	Medication adherence counseling is not a required element of LPAP. Not all LPAP staff have the training or expertise to conduct adherence counseling, and adherence counseling should be provided as part of Outpatient/Ambulatory Health Services.
Viral Suppression section	5. Percentage of clients accessing HIV medication assistance for more than 60 days have documentation of viral suppression.	Entire section has been removed.	Measurement of viral suppression for a service category is an activity of the clinical quality management (CQM) program, and does not necessarily reflect the quality or consistency of LPAP services. HRSA has provided technical assistance indicating that CQM measures should be removed from service standard monitoring.

Medical Case Management (Including Treatment Adherence Services) Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Intake—Medical Case Management	Per 15 minutes
Medical Case Management (Including Treatment Adherence Services)	Per 15 minutes
Medical Case Management Recertification	Per 15 minutes
Plan Reevaluation	Per 15 minutes
Service Coordination and Medical Follow-up	Per 15 minutes
Treatment Adherence Counseling	Per 15 minutes

Health Resources and Services Administration (HRSA) Description:

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 includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

In addition to providing the medically oriented activities above, MCM 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 and Exchanges).

Program Guidance:

Medical Case Management (MCM) services have the objective of improving health care outcomes, whereas Non-Medical Case Management services (NMCM) have the objective of providing guidance and assistance in improving access to needed services. Agencies should report client visits to ensure readiness for and adherence to complex HIV treatments as MCM or Outpatient/Ambulatory Health Services (OAHS). Agencies should report treatment adherence services provided during an MCM visit in the MCM service category and services provided during an OAHS visit under the OAHS service category.

Clients may simultaneously receive MCM and NMCM if they otherwise lack access to essential case management services. Agencies providing both services should evaluate dually enrolled clients to ensure that simultaneous case management is necessary, does not duplicate services, and is not an undue burden on clients. Documentation in client charts should demonstrate that the services provided are distinct and necessary.

Agencies should report referrals for health care and support services provided during a case management visit in the appropriate service category (i.e., MCM or NMCM). For referral services an MCM client receives outside of a case management visit or not by their medical case manager, agencies should report these under Referral for Health Care and Support Services (RHCS), provided they meet RHCS service standards. Recipients should take steps to ensure agencies do not bill services in duplicate across different service categories.

Limitations:

MCM is a service based on need and is not appropriate or necessary for every client accessing services. MCM is designed to serve only individuals who have complex needs related to their ability to access and maintain HIV medical care. Agencies should not use MCM as the only access point for medical care and other agency services. Agencies should only enroll clients in MCM services if they need these services to access and maintain medical care. Agencies should graduate clients when they can maintain their own medical care or have needs that other support categories (e.g., NMCM or RHCS) can address adequately. However, some clients may have an ongoing need for MCM due to mental illness, behavioral or developmental disorders, or other issues. This results in a continual need for assistance to improve or maintain health outcomes.

Services:

Core components of MCM services are:

1. **Coordination of Medical Care:** Scheduling appointments for treatments and referrals, including labs, screenings, medical specialist appointments, mental health treatment, oral health care, and substance use treatment.
2. **Follow-up of Medical Treatments:** Includes accompanying clients to medical appointments; calling, emailing, texting, or writing letters to clients with respect to various treatments to ensure they keep appointments or reschedule as needed. Additionally, follow-up ensures clients have appropriate documentation, transportation, and understanding of procedures.
3. **Treatment Adherence:** The provision of counseling or special programs to ensure adherence to HIV treatments to achieve and maintain viral suppression.

Key activities include:

- An 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 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 review of the utilization of services

Universal Standards:

Service providers for Medical Case Management must follow HRSA and DSHS Universal Standards #-## and ###-###.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Initial Comprehensive Assessment: Case managers must complete the initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services. The assessment must include, at a minimum: • Client health history, health status, and health-related needs • Substance use disorder screening, using a valid and reliable tool • Mental health screen, using a valid and reliable tool • Risk assessment • Medication adherence screening • Client strengths and resources • Other agencies that serve the client and their household • Progress notes from assessment session(s) Find screening tools for substance use, mental health, risk assessment, and medication adherence at Texas HIV Case Management | Texas DSHS. Case management staff should re-administer screening tools, such as a substance use disorder screen or a mental health screen, if there is concern about changes to the client's status. If the client exits and then re-enters MCM, the case manager should complete the comprehensive assessment again in its entirety. Otherwise, the comprehensive assessment is only required at the time of entry to services and not annually thereafter.	1. Percentage of clients that completed an initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services. The assessment must include: 1a: Valid and reliable substance use disorder screening 1b: Valid and reliable mental health screening 1c: Risk assessment 1d: Medication adherence screening tool

Acuity Level and Client Contact: Case managers should assess client acuity using an approved acuity scoring tool at the time of the initial comprehensive assessment. Staff should review acuity levels every three months at a minimum to ensure the acuity is still appropriate for the client's needs. Case managers should document the review even if they do not make any changes to the client's acuity. Each interaction with a client has the potential to change acuity scores in specific categories, and staff should document any changes in a client's acuity. The frequency of contact between case management staff and the client should be appropriate for the client's level of acuity. Staff providing MCM services have the discretion to determine whether a client needs a higher frequency of contact or to remain in MCM services despite a low score on the acuity tool. The case management staff should document any additional information that is relevant to their assessment of the client's true acuity, such as additional needs not captured by the tool.	2. Percentage of clients with an acuity assessment that includes: 2a. Acuity level assessed using an approved acuity tool at the time of initial comprehensive assessment. 2b. Acuity level reviewed every three months, at a minimum, using an approved acuity tool. 2c. Frequency of contact by staff matches the current acuity level.
Care Planning: The client and the staff providing MCM services will actively work together to develop and implement the medical case management care plan. Care plans must include, at a minimum: • Problem statement based on the client's need • One to three current goals • Interventions (such as tasks, referrals, or service deliveries) • Individuals responsible for the activity (such as the staff providing MCM services, the client, other team members, the client's family, or another support	3. Percentage of clients with a care plan that contains all of the following: 3a: Problem statement or need 3b: Goal(s) 3c: Intervention (tasks, referral, service delivery) 3d: Responsible party for the activity 3e: Timeframe for completion 4. Percentage of clients with care plans updated at least every six months. 5. Percentage of client records with case notes that

person) • Anticipated time for the completion of each intervention Regular case notes should describe the progress toward meeting care plan goals. Case managers should update the plan with the outcomes of interventions and revise or amend the plan in response to changes in the client's life circumstances or goals. Staff should update tasks, referrals, and services as they identify or complete them, not at set intervals. Case managers must update care plans at least every six months with documentation that they have reviewed and revised, if appropriate, all required elements (problem statement, goals, interventions, responsible party, and timeframe).	document the progress towards meeting goal(s) identified in the care plan.
Education: MCM staff should provide education to clients to ensure an understanding of key areas of health and HIV treatment. Education is an ongoing process that case managers should begin at the initiation of MCM services and repeat at least annually. Staff should ensure the education is appropriate to the client's age, level of education, and existing knowledge and health literacy. Education must include the following: • The HIV disease process • Medication adherence and the goals of antiretroviral therapy • Risk reduction, which may address both HIV transmission risk and substance use risk, as applicable • Nutrition • Oral health	6. Percentage of clients with documentation of education provided, to include the following: 6a: The HIV disease process 6b: Medication adherence and goals of antiretroviral therapy 6c: Risk reduction, which may address both HIV transmission risk and substance use risk, as applicable 6d: Nutrition 6e: Oral health

Viral Suppression and Treatment Adherence: An assessment of treatment adherence support needs and client education should begin as soon as the client accesses MCM services and should continue until the agency discharges the client from MCM services. Services should involve an individually tailored adherence intervention program, and staff providing MCM should continuously reinforce the importance of treatment adherence. If clients miss appointments for medical care, case managers should contact clients to follow up. Staff should discuss barriers to appointment attendance and collaborate with clients to address these barriers. Staff should address the following as part of a comprehensive treatment adherence program: • The client's current level of medication and treatment adherence. • Attendance at appointments for core medical services and understanding of the importance of regular attendance at medical and non-medical appointments. • Potential adverse side effects associated with HIV treatment and the impact on functioning and adherence. • Knowledge of HIV medications, their role in achieving positive health outcomes, and techniques to manage side effects. • Client relationships with family, friends, or community support systems, which may either promote or hinder client adherence to treatment protocols.	7. Percentage of clients who received treatment counseling, as indicated. 8. Percentage of charts with documentation of follow-up after any missed medical appointments, including identified barriers to appointment attendance and efforts to address barriers.

Referral and Follow-Up: Staff providing MCM services will work with the client to determine barriers to referrals and facilitate access to referrals. When staff refer clients for services elsewhere, case notes should include documentation of whether the client attended the appointment and the outcome of the referral. For clients	9. Percentage of clients with documentation that staff initiated their referrals immediately. 10. Percentage of clients with referrals that have documentation of follow-up to the referral, including appointments attended and the result of the referral.

who decline a referral, the case notes should also document this declination. The care plan may address challenges to completing the referral and any case management interventions.	
Case Closure and Graduation: Clients who are no longer engaged in active medical case management services should have their cases closed with a case closure summary documented in the client's chart. This should include both a brief narrative progress note, and a formal case closure and graduation summary. The case management supervisor should review and sign all closed cases. Staff must notify clients of plans for case closure and provide written documentation explaining the reason for closure or graduation and the process to follow if the client elects to appeal the case closure or graduation from service. At the time of case closure, case management staff should also provide clients with contact information, including the process for re-establishing MCM services. A client is "out of care" if three attempts to contact the client (via phone, e-mail, or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) as permitted by client authorization when trying to re-engage a client. The agency should initiate case closure proceedings 30 days following the third attempt at contact. Common reasons for case closure include: • The agency refers the client to another medical case management program • Client relocates outside of the service area • Client chooses to terminate services	11. Percentage of closed cases with discharged documentation, including: 11a. Formal case closure or graduation summary that documents the reason for case closure. 11b. Supervisor signature and approval. 11c. Client notification, including the provision of written documentation explaining the reason for case closure or graduation. 11d. Client given information on appealing case closure and the process to re-establish MCM in the future.

• Client is no longer eligible for services due to not meeting eligibility requirements • Client does not engage in service despite at least three attempts to engage client within a 30-day consecutive time period • Client is or will be incarcerated for more than six months in a correctional facility • Provider initiated termination due to behavioral violations, per agency's policy and procedures • Client's death Graduation criteria: • Client completed medical case management goals • Client is no longer in need of medical case management services	

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2023.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, 22 Oct. 2018.

MCM crosswalk - 08-13-24

Location of change	Prior Version	New Version	Notes
Initial Comprehensive Assessment section	1. Percentage of clients that have a completed initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services. The assessment must include: 1a: Valid and reliable substance use disorder screening, such as SAMISS 1b: Valid and reliable mental health screening 1c: Risk assessment 1d: Medication adherence screening tool	1. Percentage of clients that have a completed initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services. The assessment must include: 1a: Valid and reliable substance use disorder screening 1b: Valid and reliable mental health screening 1c: Risk assessment 1d: Medication adherence screening tool	This measure was edited to remove reference to SAMISS to avoid being misinterpreted as requiring SAMISS specifically. A different substance use disorder screening is acceptable if it is validated.
Acuity Level and Client Contact section	2. Percentage of clients who had their acuity level assessed using an approved acuity tool at the time of the initial comprehensive assessment. 3. Percentage of clients whose acuity level was reviewed every 3 months, at a minimum, using an approved acuity tool. 4. Percentage of clients whose frequency of contact by staff matches their current acuity level.	2. Percentage of clients with an acuity assessment that includes: 2a. Acuity level assessed using an approved acuity tool at the time of initial comprehensive assessment. 2b. Acuity level reviewed every 3 months, at a minimum, using an approved acuity tool. 2c. Frequency of contact by staff matches current acuity level.	These three measures were collapsed into one measure with submeasures and simplified language.

Care Planning section	5. Percentage of clients with a care plan that contains all of the following: 5a: Problem statement or need 5b: Goal(s) 5c: Intervention (tasks, referral, service delivery) 5d: Responsible party for the activity 5e: Timeframe for completion 6. Percentage of clients with care plans that have been updated at least every 6 months. 7. Percentage of client records with case notes that document the progress towards meeting goal(s) identified in the care plan.	3. Percentage of clients with a care plan that contains all of the following: 3a: Problem statement or need 5b: Goal(s) 3c: Intervention (tasks, referral, service delivery) 5d: Responsible party for the activity 3e: Timeframe for completion 4. Percentage of clients with care plans that have been updated at least every 6 months. 5. Percentage of client records with case notes that document the progress towards meeting goal(s) identified in the care plan.	No change
Education section	8. Percentage of clients with documentation of education provided, to include the following: 8a: The HIV disease process 8b: Medication adherence and goals of antiretroviral therapy 8c: Risk reduction, which may address both HIV transmission risk and substance use risk, as applicable 8d: Nutrition 8e: Oral health	6. Percentage of clients with documentation of education provided, to include the following: 6a: The HIV disease process 6b: Medication adherence and goals of antiretroviral therapy 6c: Risk reduction, which may address both HIV transmission risk and substance use risk, as applicable 6d: Nutrition 6e: Oral health	No change

Viral Suppression and Treatment Adherence section	9. Percentage of clients who were provided treatment counseling, as indicated. 10. Percentage of clients who did not have a medical visit in the last 6 months of the measurement year, according to the documentation in the medical case management record. (HRSA HAB measure – DSHS language clarification) 11. 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 – DSHS language clarification)	7. Percentage of clients who were provided treatment counseling, as indicated. 8. Percentage of charts with documentation of follow-up after any missed medical appointments, including identified barriers to appointment attendance and efforts to address barriers.	Measures 10 and 11 have been removed per recent technical assistance from HRSA. They were designed to evaluate programs for efficacy and not to evaluate whether services are being provided consistently and to a minimum level of quality. These measures were replaced with a measure (measure 8) asking staff to address missed appointments and associated barriers to result in a staff-driven, as opposed to client-driven, measure.
Referral and Follow-Up section	12. Percentage of clients with documentation that referrals were initiated immediately. 13. Percentage of clients with documentation that referrals were declined by the client, as applicable. 14. Percentage of clients with referrals that have documentation of follow-up to the referral, including appointment attended and the result of the referral.	9. Percentage of clients with documentation that referrals were initiated immediately. 10. Percentage of clients with referrals that have documentation of follow-up to the referral, including appointment attended and the result of the referral.	Measure 13 is typically N/A during the majority of chart reviews and was therefore removed.

Case Closure and Graduation section	15. Percentage of closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure or graduation summary). 16. Percentage of closed cases with documentation of supervisor signature and approval on closure summary (electronic review is acceptable). 17. Percentage of clients that are notified (through face-to-face meeting, telephone conversation, or letter) of plans for MCM case closure. 18. Percentage of clients with written documentation provided to the client explaining the reason(s) for case closure or graduation and the process to be followed if the client elects to appeal the case closure or graduation from service. 19. Percentage of clients who are provided with contact information and the process for re-establishment in MCM at the time of case	11. Percentage of closed cases with discharged documentation including: 11a. Formal case closure or graduation summary that documents the reason for case closure. 11b. Supervisor signature and approval. 11c. Client notification, including the provision of written documentation explaining the reason for case closure or graduation. 11d. Client given information on appealing case closure and the process to re-establish MCM in the future.	These measures were collapsed into one measure with submeasures and simplified language in response to the number of MCM measures addressing case closure procedures being disproportionally weighted relative to other aspects of MCM (assessment, education, care plans, etc.).

Non-Medical Case Management Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Case Management (Non-Medical)	Per 15 minutes
Intake—Non-Medical Case Management	Per 15 minutes
Non-Medical Case Management Recertification	Per 15 minutes

Health Resources and Services Administration (HRSA) Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program (CHIP), 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).

Program Guidance:

The objective of NMCM Services is to provide coordination, guidance, and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management (MCM) Services have as their objective improving health care

outcomes.

Agencies should report referrals for health care and support services provided during a case management visit (medical and non-medical) in the appropriate case management service category (i.e., MCM or NMCM). If a client enrolled in MCM receives referral services that the agency did not provide during a case management visit or by the client's medical case manager, agencies can report these under Referral for Health Care and Support Services (RHCS), provided the service standards for RHCS are met. Recipients should take steps to ensure services are not billed in duplicate across different service categories.

Clients may simultaneously receive MCM and NMCM if they lack access to essential case management services. Agencies that provide both services should coordinate and carefully evaluate clients who are dually enrolled to ensure that simultaneous case management is necessary and does not constitute either a duplication of services or an undue burden on clients. Documentation in client charts should demonstrate that the services the clients received are distinct and necessary.

Limitations:

NMCM is a service based on need and is not appropriate or necessary for every client accessing services. NMCM services are for individuals who cannot access or remain in medical or support services on their own. Agencies should not use this service as the only access point for medical care and other agency services. Agencies should not enroll clients in NMCM services if they do not need guidance and assistance in improving or gaining access to needed services. Agencies should graduate clients when they can maintain needed services independently or when they have needs that the agencies can adequately address under another support category, such as RHCS.

Services:

Key activities of NMCM 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;
- Client-specific advocacy and review of the 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; and

- Ongoing assessment of the client's needs and available resources to support those needs.

In addition, NMCM 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, or Marketplace insurance plans).

Universal Standards:

Service providers for Non-Medical Case Management must follow HRSA and DSHS Universal Standards 1-## and ###-###

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
Initial Assessment: Case managers should conduct an initial assessment for all NMCM clients to determine their need for medical and support services, as well as barriers to accessing services, client strengths, and resources. 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. The assessment should determine client needs in the following areas: • Access to medical care and medication • Food security and nutritional services • Financial needs and entitlements • Housing security • Transportation • Legal assistance • Linguistic services • Any other applicable medical or support service needs Case managers should also include the following in the initial assessment: • Client strengths and resources • Other agencies that serve clients and households	1. Percentage of clients with a completed initial assessment within 30 calendar days of the first appointment to access NMCM services.

Care Planning: 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 based on client need • One to three current goals • Interventions to achieve goals (such as tasks, referrals, or service deliveries) • Individuals responsible for the activity (such as case management staff, the client, other team members, the client's family, or another support person) • Anticipated time for the completion of each intervention Staff should update the care plan with outcomes and revise or amend the plan in response to changes in access to care and services. Case managers should update tasks, types of assistance in accessing services, and services as they identify or complete them, not at set intervals. Case managers must update care plans at least once every six months and should document that they reviewed and revised, if appropriate, all required elements (problem statement or need, goals, interventions, responsible party, and timeframe).	2. Percentage of clients with a care plan that contains all of the following: 2a: Problem statement or need; 2b: Goal(s); 2c: Intervention (tasks, referral, service delivery); 2d: Responsible party for the activity; and 2e: Timeframe for completion. 3. Percentage of clients with care plans that have been updated at least once every six months.
Assistance in Accessing Services and Follow-Up: Case management staff should work with the client to overcome barriers to accessing services and complete the interventions identified in the care plan. Case managers should base assistance on the needs identified, collaboratively with the client, during the care planning process. If the client denies any assistance, staff should document this. When clients receive assistance in accessing services outside of the agency providing NMCM, case notes must	4. Percentage of clients with documentation of assistance provided, based on the client care plan. 5. Percentage of clients who received assistance in accessing outside services that have documentation of follow-up.

include documentation of follow-up and outcome.	
Case Closure and Graduation: Agencies should close cases and document in the client's chart when clients are no longer engaged in active case management services. This should include brief narrative progress notes, a formal case closure, and a graduation summary. The case management supervisor should review and sign all closed cases. Staff must notify clients of plans for case closure and provide written documentation explaining the reason for closure or graduation and the process clients can follow if they elect to appeal the case closure or graduation from service. At the time of case closure, agencies should also provide clients with detailed information on how to reestablish NMCM services. A client is "out of care" if three attempts to contact the client (via phone, e-mail, or written correspondence) are unsuccessful and the agency has given the client 30 days from initial contact to respond. Staff should utilize multiple methods of contact (i.e., phone, text, e-mail, or certified letter), as permitted by client authorization, when trying to re-engage a client. The agency should initiate case closure proceedings 30 days following the third attempt at contact. Common reasons for case closure include: • The client no longer needs non-medical case management services. • The provider refers the client to another case management program. • The client relocates outside of the service area. • The client chooses to terminate services.	6. Percentage of closed cases with discharged documentation, including: 6a. A formal case closure or graduation summary that documents the reason for case closure; 6b. A supervisor's signature and approval; 6c. Client notification, including the provision of written documentation explaining the reason for case closure or graduation; and 6d. The provider gives the client information on appealing the case closure and the process to re-establish NMCM in the future.

• The client is no longer eligible for services due to not meeting eligibility requirements. • The client is lost to care or does not engage in service. • The client is or will be incarcerated for more than six months in a correctional facility. • The provider initiated termination due to behavioral violations, per the agency's policy and procedures. • The client's death. Graduation criteria: • The client completed case management goals for increased access to services or care needs. • The client no longer needs case management services (e.g., client can resolve needs independent of case management assistance or has needs that RHCS can adequately meet).	

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2023.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, 22 Oct. 2018.

Non-MCM crosswalk - 08-13-24

Location of change	Prior Version	New Version	Notes
Assistance in Accessing Services and Follow-Up section	5. Percentage of clients with documentation of any assistance denied by the client.	Removed	This measure was removed as it is NA for the majority of clients and typically only unmet in situations where there is no NMCM documentation to review.
Case Closure and Graduation section	7. Percentage of closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure or graduation summary). 8. Percentage of closed cases with documentation of supervisor signature and approval on closure summary (electronic review is acceptable). 9. Percentage of clients with closed cases who were provided with information about the reason for discharge, the process to appeal their discharge, and	6. Percentage of closed cases with discharged documentation including: 6a. A formal case closure or graduation summary that documents the reason for case closure; 6b. A supervisor's signature and approval; 6c. Client notification, including the provision of written documentation explaining the reason for case closure or graduation; and 6d. The provider gives the client information on appealing the case closure and the process to re-establish NMCM in the future.	Measures 7-9 were consolidated to match the updated MCM discharge measure, retaining the required elements while keeping discharge from weighing too heavily in the overall category score.

Referral for Healthcare and Support Services Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Application	Per application
Referral for Healthcare and Support Services	Per referral

Health Resources and Services Administration (HRSA) Description:

Referral for Health Care and Support Services (RHCS) 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 HIV/AIDS Program (RWHAP) eligible clients to obtain access to public or private programs for which they may be eligible.

Program Guidance:

Agencies report referrals for health care and support services provided by Outpatient/Ambulatory Health Care professionals under the Outpatient/Ambulatory Health Services (OAHS) category.

Agencies report referrals for health care and support services provided during a Medical Case Management (MCM) or Non-Medical Case Management (NMCM) visit in the appropriate case management service category (i.e., MCM or NMCM). Agencies can report referral services an MCM or NMCM enrolled client receives under RHCS, including those the client's medical case manager did not provide or those received outside of a case management visit, as long as they meet RHCS service standards. Recipients take steps to ensure they do not bill services in duplicate across different service categories.

Recipients can use RWHAP Part B and State Services (RW and SS) funds to provide

transitional social services to establish or reestablish linkages to the community. Referral services that link a soon-to-be-released incarcerated person with primary care are an example of appropriate transitional social services. Transitional social services may not exceed 180 days, per DSHS Policy 591.00 Limitations on Ryan White and State Service Funds for Incarcerated Persons in Community Facilities, Section 5.3.

Limitations:

Recipients cannot use RHCS funds to duplicate services provided through other service categories.

Services:

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

RHCS providers may assist RWHAP-eligible clients with obtaining needed HIV Care Services medical or support services, and services available through the Texas HIV Medication Program (THMP) including:

- AIDS Drug Assistance Program (ADAP)
- State Pharmaceutical Assistance Program (SPAP)
- Texas Insurance Assistance Program (TIAP)

Benefits counseling services facilitate a client's access to public or private health and disability benefits and programs. This service category works to maximize public funding by assisting clients in identifying available health and disability benefits supported by funding streams other than RW and SS funds. Agencies educate clients about and assist with accessing and securing available public and private benefits and entitlement programs.

Referrals for Core Medical and Support Services provide clients with assistance in accessing medical and support services to improve engagement in the health care system and the HIV continuum of care through the referral process. Referrals may include benefits counseling and application assistance programs for Marketplace plans, health insurance, Medicaid, Medicare, and medication payment plans or programs. These services focus on assisting a client's entry into and movement through the care service delivery network such that RW and SS funds are the

payer of last resort.

Universal Standards:

Service providers for Referral for Healthcare and Support Services follow HRSA and DSHS Universal Standards 1-## and ###-###.

Service Standards and Measures:

The following standards and measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure

Application Assistance and Benefits Counseling:
Staff 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 these benefits and resources.
Staff assist clients with the following, as appropriate:
• Eligibility to receive HIV Services
  ▸ RHCS providers may assist RWHAP-eligible clients with obtaining needed HIV Care Services medical or support services, and services available through THMP (ADAP, SPAP, and TIAP)
• Pharmaceutical Manufacturer's Patient Assistance Programs
• Health insurance plans and payment options:
  ▸ Texas Medicaid's Health Insurance Premium Payment program
  ▸ Continuation of Health Coverage (COBRA)
  ▸ Social Security programs, such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)
  ▸ Veterans Administration (VA) benefits
  ▸ Women, Infants and Children (WIC)
• Other public or private benefits programs
	1. Percentage of clients with documented education provided on applicable public or private benefit programs.
	2. Percentage of clients with applicable public or private benefit applications completed within 14 business days of the eligibility determination date.
	3. Percentage of clients with documentation of follow-up and results within 90 days of a completed benefit application.

Referrals for Core Medical and Support Services: Assist clients with accessing health care and support services to support their engagement in the health care system and the HIV continuum of care through the referral process.
 	
Staff may assist clients with referrals to the following, as applicable:
• Benefits counseling and application assistance programs such as:
  ▸ Marketplace navigators, certified application assistors, or insurance agents and brokers.
  ▸ Texas Health Information, Counseling and Advocacy Program for Medicare.
  ▸ Texas Health and Human Services' (HHS) Community Partner Program (CPP) for Medicaid and other state benefits.
• Health care and support services not provided as part of an OAHS visit.
• Health Insurance Premium and Cost-Sharing Assistance (HIA) for assistance with insurance costs.
• Additional core and support services applicable to the client's needs.
 	
Staff complete follow-ups for clients. If staff give a client a referral to self-complete, RHCS staff follow up with the client within 10 business days to determine the outcome and further assistance needed. If staff assisted the client with scheduling an appointment for a referral at the time of service, RHCS staff follow up with the client within 10 business days of the scheduled appointment to determine the outcome and further assistance needed.
	4. Percentage of clients who received a referral to core or support service who have documentation that they received education on how to access these services.
	5. Percentage of clients who received a referral to core or support services that had documentation of a follow-up within 10 business days of a referral given to the client to self-complete OR 10 business days from the scheduled appointment if an appointment was set at time of referral.

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2023.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2023.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources and Services Administration, 22 Oct. 2018.

Texas Department of State Health Services. "591.000 Limitations on Ryan White and State Services Funds for Incarcerated Persons in Community Facilities." www.dshs.texas.gov, 21 Mar. 2019, www.dshs.texas.gov/hivstd/policy/policies/591-000.

Location of change	Prior Version	New Version	Notes
Benefits Counseling section	**Benefits Counseling:** Activities should be client-centered and facilitate 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 private benefits and resources for which they are eligible. Staff should 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 these benefits and resources. Staff should assist clients with the following resources, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health insurance plans and payment options (Health Insurance Premium Payment, Continuation of Health Coverage, Medicaid, Medicare, Affordable Care Act Marketplace insurance) • Supplemental Nutrition Assistance Program (SNAP) • Pharmaceutical patient assistance programs (PAPs) • Social Security programs, such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) • Temporary Assistance to Needy Families (TANF) • Veterans Administration (VA) benefits • Women, Infants and Children (WIC) • Other public or private benefits programs • Other professional services Staff should assist eligible clients with the completion of the	**Application Assistance and Benefits Counseling:** Application Assistance and Benefits Counseling Staff should 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 these benefits and resources. Staff should assist clients with the following, as appropriate: • Eligibility to Receive HIV Services ○ RHCS providers may assist RWHAP-eligible clients with obtaining needed HIV Care Services medical or support services, and services available through THMP (ADAP, SPAP, and TIAP) • Pharmaceutical Manufacturer's Patient Assistance Programs • Health insurance plans and payment options: ○ Texas Medicaid's Health Insurance Premium Payment program ○ Continuation of Health Coverage (COBRA) ○ Social Security programs, such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) ○ Veterans Administration (VA) benefits ○ Women, Infants and Children (WIC) • Other public or private benefits programs	This standard was retitled and reworded to be more comprehensible and directly reference the use of this service category for eligibility, THMP, and care.
Health Care Services section	**Health Care Services**: Activities should assist clients in accessing health care and support services to support their engagement in the health care system and the HIV continuum of care. Staff should assist eligible clients with referrals to the following, as applicable: • Marketplace plans, other health insurance, or medication payment plans or programs. • Health Insurance Premium and Cost-Sharing Assistance (HIA) for assistance with insurance costs • Additional core services applicable to the client's needs, with education provided to the client on how to access these services • Additional support services applicable to the client's needs, with education provided to the client on how to access these services.	**Referrals for Core Medical and Support Services**: Assist clients with accessing health care and support services to support their engagement in the health care system and the HIV continuum of care through the referral process. Staff may assist clients with referrals to the following, as applicable: • Benefits counseling and application assistance programs such as: ○ Marketplace Navigators, Certified Application Assistors, or insurance agents and brokers. ○ Texas Health Information, Counseling and Advocacy Program for Medicare. ○ Texas Health and Human Services' (HHS) Community Partner Program (CPP) for Medicaid and other state benefits. • Health care and support services not provided as part of an OAHS visit. • Health Insurance Premium and Cost-Sharing Assistance (HIA) for assistance with insurance costs. • Additional core and support services applicable to the client's needs.	This standard was retitled and reworded to be more comprehensible and provide additional examples of referrals.
Health Care Services section	Measure 4. Percentage of clients who received assistance in accessing health insurance, as applicable.	N/A	This measure was removed.