Houston Area HIV Services Ryan White Planning Council

Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax
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MEMORANDUM

To: Steering Committee Members:
Tana Pradia, Chair
Allen Murray, Vice Chair
Crystal Starr, Secretary
Veronica Ardoin, Co-Chair, Affected Community Committee
Rodney Mills, Co-Chair, Affected Community Committee
Daphne L. Jones, Co-Chair, Comprehensive HIV Planning Committee
Steven Vargas, Co-Chair, Comprehensive HIV Planning Committee
Ronnie Galley, Co-Chair, Operations Committee
Carol Suazo, Co-Chair, Operations Committee
Bobby Cruz, Co-Chair, Priority and Allocations Committee
Denis Kelly, Co-Chair, Quality Improvement Committee
Pete Rodriguez, Co-Chair, Quality Improvement Committee

Copy:
Carin Martin
Samantha Bowen
Yvette Garvin
Sha'Terra Johnson-Fairley
Amber Harbolt
Diane Beck
Ann Robison
David Williams (email only)

From: Tori Williams

Date: Thursday, May 28, 2020

Re: Meeting Announcement

Please note that there will be a:

Steering Committee Meeting
12 noon, Thursday, June 4, 2020

Zoom Conference Call – Please do not come to the office

Join Zoom Meeting by clicking onto: https://us02web.zoom.us/j/499715637
Meeting ID: 499 715 637
No password
Or, call 346 248-7799

Please contact Rod to RSVP, even if you cannot attend. Rod can be reached by telephone at: 832 927-7926 or by email at: Rodriga.Avila@cjo.hctx.net.

Thank you!

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
<<>>
STEERING COMMITTEE

AGENDA

12 noon, Thursday, June 4, 2020

Meeting Location: Online or via phone – Please do not come in person
Join Zoom Meeting by clicking on this link: https://us02web.zoom.us/j/499715637
Meeting ID: 499 715 637
To join via telephone call: (346) 248-7799

I. Call to Order — Tana Pradia, Chair, Ryan White Planning Council
   A. Welcoming Remarks
   B. Moment of Reflection
   C. Select the Committee Co-Chair who will be voting today
   D. Adoption of the Agenda
   E. Adoption of the Minutes

II. Public Comment 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 yourself, 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. Reports from Committees

A. Comprehensive HIV Planning Committee — Daphne L. Jones and Steven Vargas, Co-Chairs
No report

B. Affected Community Committee — Veronica Ardoin and Rodney Mills, Co-Chairs
Item: Training: COVI-19 and Living with HIV
Recommended Action: FYI: Pete Rodriguez, RN, presented the attached PowerPoint presentation on COVID-19 and Living with HIV.

Item: Public Hearing for the 2021 How To Best Meet the Need Results
Recommended Action: FYI: On Thursday, May 14, 2020, the Affected Community Committee recorded the public hearing to announce proposed changes to the FY 2021 Ryan White service definitions. The video is available to watch on YouTube, see the website for the link. Public comments will be accepted until noon on June 2, 2020.

C. Quality Improvement Committee — Denis Kelly and Pete Rodriguez, Co-Chairs

Item: Reports from the Administrative Agent – Part A/MAI*
Recommended Action: FYI: See the attached reports from the Part A/MAI Administrative Agent:

- FY19 Procurement Report – Part A & MAI, dated 04/30/20
- FY19 Service Utilization Report – Part A & MAI, dated 03/02/20

Item: Reports from the Administrative Agent – Part B/SS
Recommended Action: FYI: See the attached reports from the Part B/ State Services Administrative Agent:

- FY 2019/20 Procurement Report 4th Qtr. Part B – dated 05/01/20
- FY 2019/20 Service Utilization 4th Qtr. Part B– dated 05/01/20
- FY 2019/20 Procurement Report DSHS SS – dated 05/01/20
- FY 2018/19 Health Insurance Program Report – dated 04/29/20

Item: FY 2021 How To Best Meet the Need Recommendations – **Emergency Financial Assistance - Other**
Recommended Action: **Motion:** *Approve the attached service definition for Emergency Financial Assistance – Other, which will be funded with Ryan White, MAI or State Services funding. The FY21 financial eligibility will be at 400% of poverty.*

Item: FY 2021 How To Best Meet the Need Recommendations
Recommended Action: **Motion:** *Approve the attached FY 2021 Service Definitions and Financial Eligibility for Ryan White Part A, Minority AIDS Initiative (MAI), Part B and State Services funded service categories, With the exception of Emergency Financial Assistance – Other, which was processed per the above motion.*

Item: Targeting for FY 2021 Service Categories
Recommended Action: **Motion:** *Approve the attached targeting chart.*

Item: Assessment of the Ryan White Program Administrative Mechanism
Recommended Action: **Motion:** *Approve the attached checklist for the 2020 Assessment of the Ryan White Program Administrative Mechanism.*

Item: 2020 Quarterly Committee Report
Recommended Action: FYI: See the attached 2020 Quarterly Committee Report.

D. Priority and Allocations Committee — Bobby Cruz and Allen Murray, Co-Chairs

Item: FY 2021 Service Priorities
Recommended Action: FYI: The Committee made Recommendations regarding the FY 2021 service category Priorities which will be presented at the July Council meeting.

Item: FY 2020 Proposed Idea Form
Recommended Action: **Motion:** *Approve page 2 of the FY 2020 Proposed Idea form.*

E.	Operations Committee Item: Youth Group Recommended Action: FYI: The Committee hosted a Zoom meeting with the Youth Group. The presenter was Pete Rodriguez, RN, who spoke about COVID-19 and Living with HIV. Rod also distributed face masks and box lunches to the youth. Item: FY 2021 How To Best Meet the Need Recommended Action: FYI: The Committee will meet this week to make recommendations regarding the 2020-21 Blue Books and the FY 2021 Office of Support Budget. Please contact Tori if you wish to attend the meeting.	Ronnie Galley and Carol Suazo, Co-Chairs
IV.	Report from Ryan White Office of Support	Tori Williams, Director
V.	Report from Ryan White Grant Administration	Carin Martin, Manager
VI.	Report from The Resource Group	Sha'Terra Johnson-Fairley, Health Planner
VII.	Announcements	
VIII.	Adjournment	

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

MINUTES

12 noon, Thursday, April 2, 2020
Meeting Location: Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Tana Pradia, Chair	Veronica Ardoin, excused	*Ryan White Grant Administration*
Allen Murray, Vice Chair	Carol Suazo	Carin Martin
Crystal Starr, Secretary		Heather Keizman
Rodney Mills		
Daphne L. Jones		*The Resource Group*
Steven Vargas		Sha'Terra Johnson-Fairley
Ronnie Galley		
Bobby Cruz		*Office of Support*
Denis Kelly		Tori Williams
Pete Rodriguez		Amber Harbolt
		Diane Beck

Call to Order: Tana Pradia, Chair, called the meeting to order at 12:12 p.m.

During the opening remarks, Pradia said that Project LEAP has been postponed until at least the end of July 2020. There are a few seats left in the class so applications are still being accepted and applicants will be interviewed via videoconferencing or telephone conference call. It is important that we all remember to keep our meeting packets in order because we will need to use them again during the Council meeting next week. Until the stay at home order is lifted, all of our meetings will be held using Zoom videoconferencing. Do not hesitate to contact Amber by email if you have questions about Zoom or want a practice session. Pradia then called for a Moment of Reflection.

Pradia invited committee co-chairs to select the co-chair who would be voting on behalf of their committee at today's meeting. Those selected to represent their committee were: Mills for Affected Community, Vargas for Comprehensive HIV Planning, Galley for Operations, Allen for Priority and Allocations and Kelly for Quality Improvement.

Adoption of the Agenda: ***Motion #1:*** *it was moved and seconded (Starr, Kelly) to adopt the agenda with one change, a motion was added under Quality Improvement to set a minimum attendance requirement for the How to Best Meet the Need workgroup meetings.* **Motion carried.**

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Starr, Galley) to approve the March 5, 2020 minutes.* **Motion carried.** Abstention: Rodriguez.

Public Comment and Announcements: None.

Reports from Committees

Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following: Needs Assessment Data for How to Best Meet the Need: The Needs Assessment Group (NAG) and the Comprehensive HIV Planning Committee each met online on March 26th to review and approve Needs Assessment data used in the *How to Best Meet the Need* Process. Please see the attached presentation outlining the data approved. ***Motion #3:*** *Approve the attached Needs Assessment introduction, Chapters 1-2, and Service-Specific Fact Sheets for use in the How to Best Meet the Need process.* **Motion carried.**

FY 2021 EIIHA Plan: ***Motion #4:*** *In order to meet HRSA grant application deadlines, request the Planning Council to allow the Comprehensive HIV Planning Committee to have final approval of the FY 2021 EIIHA Plan target populations, provided that:*

- *The FY 2021 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and*
- *The recommended FY 2021 EIIHA Plan target populations are distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.*

Motion carried.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following: Training: *How To Best Meet the Need* Process: Although the Committee did not meet in March, members received the training materials for the *How To Best Meet the Need* process and a time when they could call Tori to walk through the information via conference call.

Quality Improvement Committee: Denis Kelly, Co-Chair, reported on the following: Information about Consumer Experiences in Care: See the attached chart, which describes reports that provide information on consumer experiences in care.

Criteria Used to Determine the FY 2021 Service Categories: ***Motion #5:*** *Approve the attached criteria which will be used to determine the FY 2021 Ryan White Part A and Part B and State Services service categories.* **Motion carried.**

Reports from Administrative Agent – Part A/MAI: See the attached reports from the Part A State Services Administrative Agent:

- Summary of Ryan White Clinical Care Chart Review Findings
- 2018 Chart Review Packet regarding:
  1. Primary Care
  2. Case Management
  3. Oral Health – Rural Target
  4. Vision Care

Reports from Administrative Agent – Part B/SS: See the attached reports from the Part B/State Services Administrative Agent:

- Health Insurance Program report DSHS – dated 03/02/20

Proposed Idea Forms: ***Motion #6:*** *Approve the 2020 Criteria and form for reviewing Proposed Ideas.* **Motion carried.**

Attendance Required for How to Best Meet the Need workgroups: Typically, there are between 15 and 30 people at How to Best Meet the Need (HTBMN) workgroup meetings. Staff is concerned that if only

3-5 people participate in a workgroup meeting this year, those 3-5 people could recommend a dramatic change to a service category or financial eligibility for a particular service. Although the Quality Improvement Committee does not have to accept the recommendation, perhaps it would be wise to set a minimum number of people eligible to vote on a motion at a workgroup meeting to manage this possible situation, otherwise the service category or financial eligibility for that service category will remain the same as in FY 2020.

Discussion: Without a minimum attendance requirement, a very small number of people could undo what Council members have processed and approved in the past. Staff will inform the Quality Improvement Committee if a small workgroup feels strongly about a change that could be made to a service category so that the Quality Improvement Committee can process the suggestion. ***Motion #7:*** *it was moved and seconded (Kelly, Vargas) that unless a minimum of 8 people eligible to vote on a particular service are present in person* or online at a How To Best Meet the Need workgroup meeting, the recommendation for that particular service category and the financial eligibility for that service will remain the same as the current fiscal year.* **Motion carried.** Abstention: Starr

* *Per the Council policies, there is only one vote per agency, if the agency representative is not conflicted.*

Tentative FY 2021 How To Best Meet the Need Schedule: See the attached, tentative schedule for the FY 2020 How To Best Meet the Need process.

Priority and Allocations Committee: No report.

Operations Committee: No report.

Report from Office of Support: Tori Williams, Director, summarized the attached report.

Report from Ryan White Grant Administration: Carin Martin, Manager, summarized the attached report.

Report from The Resource Group: Sha'Terra Johnson-Fairly, Health Planner, summarized the attached report.

Announcements: Vargas said that AAMA is conducting all of their support groups virtually and opening them up to all. Williams said she heard that AA meetings are being conducted virtually. Kelly said they are collecting funds to order hand sanitizer for the homeless. He said they are hoping to hear soon about the availability of hotel rooms for the homeless. Pradia said she is making masks and that the Parks and Recreation Department is distributing lunches.

Adjournment: The meeting adjourned at 1:41 p.m.

Submitted by:

Tori Williams, Director Date

Approved by:

Committee Chair Date

2020 Steering Committee Voting Record for Meeting Date 04/02/20

C = Chaired the meeting, JA = Just arrived, LM = Left the meeting,
VP = Participated via telephone, nv = Non-voting member

Aff-Affected Community Committee, Comp-Comprehensive HIV Planning Committee, Op-Operations Committee, PA-Priority and Allocations Committee, QI-Quality Improvement Committee

MEMBERS	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** NA for HTBMN **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Tana Pradia, Chair				C				C				C
Allen Murray, Vice Chair		X				X				X		
Crystal Starr, Secretary		X				X				X		
Rodney Mills, Aff		X				X				X		
Steven Vargas, Comp		X				X				X		
Ronnie Galley, Op		X				X				X		
Denis Kelly, QI		X				X				X		
Non-voting members at the meeting:												
Daphne L. Jones, Comp												
Bobby Cruz, PA												
Pete Rodriguez, QI												
Absent members:												
Veronica Ardoin, Aff												
Carol Suazo, Op												

MEMBERS	**Motion #4** EIIHA **Carried**				**Motion #5** FY21 Criteria for Svc Cats **Carried**				**Motion #6** Proposed Idea Criteria/Form **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Tana Pradia, Chair				C				C				C
Allen Murray, Vice Chair, PA		X				X				X		
Crystal Starr, Secretary		X				X				X		
Rodney Mills, Aff		X				X				X		
Steven Vargas, Comp		X				X				X		
Ronnie Galley, Op		X				X				X		
Denis Kelly, QI		X				X						X
Non-voting members at the meeting:												
Daphne L. Jones, Comp												
Bobby Cruz, PA												
Pete Rodriguez, QI												
Absent members:												
Veronica Ardoin, Aff												
Carol Suazo, Op												

MEMBERS	Motion #7 HTBMN Wg Attendance Carried			
	Absent	Yes	No	Abstain
Tana Pradia, Chair				C
Allen Murray, Vice Chair		X		
Crystal Starr, Secretary				X
Rodney Mills, Aff		X		
Steven Vargas, Comp		X		
Ronnie Galley, Op		X		
Denis Kelly, QI		X		
Non-voting members at the meeting:				
Daphne L. Jones, Comp				
Bobby Cruz, PA				
Pete Rodriguez, QI				
Absent members:				
Veronica Ardoin, Aff				
Carol Suazo, Op				

Public Comment

In an effort to save paper, see attached two sided copies

PUBLIC COMMENT – 04–24-20

Esteemed Ryan White Planning Councilmembers,

I am writing in support of using, under the Emergency Financial Assistance service category, funds to provide rapid response financial assistance to People With HIV (PWH) impacted by the COVID-19 pandemic and other disasters. Our current system is not built to act swiftly. Many PWH experience frustration when they need financial assistance and realize the monthly expenses owed tomorrow may not be available for two weeks to a month. And this is after the time taken to secure appointments, gather requested documentation, fill out paperwork, sign Consent forms, etc. "Rapid response" would need to be part of this service definition for processes to be developed which simplify or streamline eligibility and reduces the time between requesting and receiving help which resolves or alleviates the crisis. The community expects an emergency response when they reach out for emergency assistance, financial or otherwise. When our community hears "emergency" they anticipate a quick response as calls placed to the police, fire department or for an ambulance. Though such a response may not be feasible within our systems of care, it is a worthy goal and could yield better than a response which takes a couple of weeks to a month and does not meet the immediate need.

Some may consider such situations a result of poor planning, or an inability to maintain or cultivate a healthy support system. This may be the case for some. For many in our EMA, this situation may present itself as a result of COVID-19 ravaging their communities, disrupting their places of employment, schooling, even worship and interrupting their flow of funds to maintain housing, utilities and food needs; interrupting their plans for the future and career plans; and interrupt the very ability to be with others for comfort or solace as they scramble to help themselves and seek help from others..

We are rapidly approaching hurricane season and still do not know when we will be completely through the COVID-19 pandemic. These two could coincide and our area could experience what Polk County just did with dealing with COVID-19 and being hit by a destructive tornado. Some PWH in our area may not be eligible for federal relief funds at that point either for a variety of reasons, including but not limited to, being undocumented. Our current funded services may not cover some of their circumstances or needs. Imagine a PWH needing to relocate temporarily due to the presence of COVID-19 in their household. Or need supplies in order self-isolate due to exposure. What about PWH living out of motels due to the same situation? Moratoriums on evictions from homes or apartments do not cover motel stays. Our HOPWA funds do not prioritize emergency shelter vouchers so do not fund them. If we intend to prevent or minimize the impact of this pandemic or other disasters on People With HIV, being able to answer their calls for help and deliver that help with a rapid response could be the difference between a Person With HIV staying in or falling out of care. It could be the difference between being safe from acquiring another life-threatening virus or hospitalization with an uncertain outcome. It could be the difference between helping to flatten the curve and not, this one or a future one.

My hope, my request, and if necessary, my demand, is "support for increased demand for emergency housing for RWHAP clients"[1] via an Emergency Financial Assistance definition which allows a rapid response to emergency situations arising from events similar to what we are experiencing now with the COVID-19 pandemic. This service definition would need to be flexible enough to accommodate the unpredictable circumstances which may arise from the variety of events which affect our area and negatively impact our efforts to end the HIV epidemic. See the attached "PBS NewsHour" report for additional information.

– Steven Vargas, HIV Advocate and Long-Term Survivor, April 23, 2020

(continued on next page)

PUBLIC COMMENT – 04–24-20

1. Quoted from the "HRSA Website Questions and Answers from 04-15-20 Conference Call, Coronavirus Disease 2019 (COVID-19) Frequently Asked Questions" under the CARES Act Funding on the last page, ninth bullet from the top.

S. Vargas submission for Public Comment. Excerpts from the report on "PBS NewsHour" (4/20/2020). For the full report, please go to https://www.pbs.org/newshour/politics/millions-of-americans-are-receiving-relief-payments-this-week-but-who-is-being-left-out

But tens of thousands of the country's most vulnerable residents will not receive this form of financial assistance this week — or, in some cases, at all. Undocumented immigrants and adult dependents don't qualify. Lower income individuals and those with disabilities will, in some cases, face extra hurdles in seeking to claim the money. And inconsistent communication about the legislation from lawmakers and the U.S. Department of Treasury has raised questions over who exactly qualifies for the relief and why certain groups are left out.

Beyond the potential challenges for those who are eligible in accessing the coronavirus aid, there are still others who have been completely left out and aren't eligible. Adults claimed as dependents, including many students and people with disabilities, will not receive anything. Parents or guardians who claim adult children on their taxes also will not receive the $500 credit provided to those with children under 17. On social media platforms, many are expressing their frustration with the decision to omit them.

Yazmin Franco, 25, came to the U.S. from Mexico as a child, but is temporarily protected from deportation under the Obama-era Deferred Action for Childhood Arrivals program. Some DACA recipients like Franco who have social security cards are eligible for payments; Franco's parents, however, are among the estimated 11 million undocumented immigrants in the United States who aren't eligible for the payment. Franco's mother was recently laid off from a grocery store position, and her father also lost his job as a landscaper due to the pandemic. In addition to daily living expenses, Franco's father has to pay for insulin to treat his diabetes without health insurance. "Having an underlying condition like my dad does, it's such a horrible feeling to not be sure what would happen to him if he were to get sick with the coronavirus," Franco said.

The legislation excludes "any nonresident alien" foreigners from receiving money. The law also denies the money to eligible taxpayers who either file a joint tax return with an undocumented person or claim an undocumented child, said Francine Lipman, a tax expert and professor with the University of Nevada, Las Vegas School of Law.

Many noncitizens who work and pay taxes, including undocumented immigrants and those with legal work visas, have lost jobs as a result of the pandemic. H-1, TN, and O-1 work visa holders are considered resident aliens and can receive aid only if they've been in the U.S. long enough to meet the "substantial presence" test.

Here is the link to an additional report from National Public Radio:

What Happens If Undocumented Immigrants Get Infected With Coronavirus? https://www.npr.org/2020/03/29/823438906/what-happens-if-undocumented-immigrants-get-infected-with-coronavirus?sc=18&f=

PUBLIC COMMENT – 04-23-20

Dear Ryan White Planning Council,

The ongoing COVID-19 pandemic has shed light on the struggle and disproportionate burden that vulnerable populations face daily. The requests for financial assistance from our patients – who mainly come from underrepresented communities – has rocketed since the "Stay Home, Work Safe" order was put in place. Many have lost their jobs and cannot afford rent or buying essential goods.

Moreover, the fact that many residents are not eligible for federal financial assistance only makes matter worse. Undocumented people are not eligible, even though they pay taxes. Additionally, people who file their taxes jointly with an undocumented person, or claim an undocumented child, are also ineligible. People with work visas can only receive their stimulus check if they can prove "substantial presence" in the country. The obstacles do not stop there.

The financial crisis that is emerging in the wake of the COVID-19 pandemic disproportionally affects those who have less access to healthcare, an impact that can be directly correlated with known social determinants of health. People are afraid to use public transportation and cannot afford ride share apps; affordable housing is becoming more and more problematic; and fear of exorbitant medical expenses continues to drive people away from care. On top of this, we are still researching the impact of this crisis on mental health – we foresee that mental health services, though costly, will emerge as a pivotal service.

There is a vulnerable population that is suffering in silence and fear. In extraordinary times like these, we need to lead with extraordinary example. Please, consider the use of emergency financial assistance funds as a rapid response aid for those ineligible for assistance.

Jonatan Gioia, MD
Research Associate
Preferred Pronouns: He/Him/His

UTHealth McGovern
The University of Texas
Medical School

Internal Medicine | Houston HIV/AIDS Research Team (HART)
6431 Fannin st | MSE R478| Houston, TX 77030
713 500 6751 tel | 713 500 0610 fax
www.uth.tmc.edu

Williams, Victoria (County Judge's Office)

From:	Richard Gamez <rcgamez@aol.com>
Sent:	Thursday, April 23, 2020 3:57 PM
To:	Williams, Victoria (County Judge's Office)
Cc:	Richard Gamez
Subject:	Emergency Financial Assistance for those ineligible

Good afternoon, Ms. Williams,

Please include this report as support for the Emergency Financial Assistance funding as a rapid response aid for those ineligible for other more immediate assistance.

https://www.washingtonpost.com/business/2020/04/05/undocumented-immigrants-coronavirus/

Thank you.
Richard Gamez
Member of the Latino HIV Task Force

The Washington Post

Business

Undocumented workers among those hit first — and worst — by the coronavirus shutdown

By Tracy Jan
April 4

Evilin Cano was dismantling a rooftop skating rink in Manhattan's Seaport district when her construction crew was notified that the venue would be closing, along with much of New York — and that she would be out of a job.

The next night, the 33-year-old undocumented day laborer from Guatemala fell ill with a fever. Her head pounded. Her throat hurt. She could not stop coughing or vomiting. And she was short of breath. She does not know whether she has covid-19 because three hospitals told her not to bother coming in for testing unless she's gasping for air.

"They told me to stay at home, don't go out, and when I can no longer breathe, call 9-1-1 for them to pick me up," Cano said.

The collapse of the U.S. economy brought about by the coronavirus pandemic has exposed the extreme vulnerabilities of millions of undocumented workers like Cano, who are disproportionately employed in industries undergoing mass layoffs as well as high-risk jobs that keep society running while many Americans self-isolate at home.

Many of the undocumented, working in construction, restaurants and other service sectors, have already lost their jobs. Others, in industries like agriculture and health care that have been declared essential, work in jobs that typically require close quarters or interacting with the public, putting them at higher risk of getting sick.

Unlike many American workers, undocumented immigrants can't count on the social safety net if they lose their jobs or get sick. Most do not have health insurance or access to paid sick leave — putting them and the people they encounter at risk. Most aren't eligible for unemployment insurance or the cash payments included in the $2 trillion relief package Congress passed last month — even if they pay taxes or their children are U.S. citizens.

"The government has announced it was going to support people affected by the coronavirus but that's for Americans — not for people like us who are undocumented," said Cano, who applied for asylum in November. "My fear is if I seek help, this country will see me as just trying to take advantage of the system."

Cano said she had been a police officer living a middle-class life in Guatemala when a gang tried to kidnap her teenage daughter, and she fled with her two eldest to New York.

She was just five days into a three-month job at the Seaport transforming what had been a temporary winterscape into a summer oasis when the contractor pulled her crew aside on March 20 and told them not to return.

Soon after Cano got sick, her daughter developed a fever, too. So did her boyfriend. Unable to seek care, Cano spent five days in bed and remains quarantined in her Brooklyn home.

Construction had been a step up for Cano. When she first came to the U.S. more than a year ago, she patched together a living at a Salvadoran restaurant, earning $50 for 13 hours of overnight work cleaning and preparing pupusas for delivery. When the till came up short, she said, the cashier would dock the difference from Cano's earnings. One night, she made so little that she had to borrow the $2.75 bus fare home.

Last June, she became a day laborer in construction — doing demolition work, painting and the finishing touches. She made $150 per nine-hour shift — enough to support her 17- and 16-year-old and still send money back to the 11- and 7-year-old she left behind with her mother.

Now, she is broke — with no savings and no income. She felt heartsick during a recent phone call home, telling her mother that no money would be coming this month.

The Brooklyn community job center where Cano and other day laborers used to gather each morning is deserted, like similar centers around the country. New contracts, now fielded over the phone, have dropped from about 20 a week before the coronavirus crisis to around five, said Ligia Guallpa, executive director of the Worker's Justice Project, which runs the center.

"I'm trying to figure out how to find another job, but I'm not healthy — and there are no jobs," Cano said. "At this point, I'm looking for anything just to support my kids."

Once she recovers, Cano plans to sell homemade tamales for $3 each — the way she supported her family over the winter when construction work was slow. She hopes it will be enough to cover their groceries.

"I cannot go back to Guatemala," Cano said. "I'd be sentencing my kids to death."

The 7 million immigrants without authorization to work in the United States make up just over 4 percent of the country's labor force, but account for at least 12 percent of workers in construction, 10 percent in hotels, and 8 percent in restaurant and food service — among the hardest hit sectors in the pandemic, according to an analysis of 2018 Census data by New American Economy. The analysis shows that undocumented immigrants also make up 14 percent of agricultural workers and 7 percent of home health aides, two industries considered critical to the health of the U.S. economy and its citizens during the coronavirus crisis.

Researchers and industry groups say undocumented laborers are significantly undercounted and comprise more than half of the workforce in some occupations, such as farmworkers.

"A lot of undocumented immigrants will be hit first — and worst — by this recession," said Orson Aguilar, director of economic policy at UnidosUS.

In the absence of a federal safety net, advocates from California to New York are pushing cities and states to provide economic relief to workers regardless of immigration status. Some have begun cobbling together funds to help undocumented workers pay rent and buy food.

Even workers who thougbt they had stability are discovering that no job is secure in the coronavirus-induced recession.

Juan, a 36-year-old head cook at a diner in Berkeley, Calif., saw his hours cut in half — to just five hours a day, for takeout and delivery only — once the governor ordered the state to shelter in place.

He donned a mask and gloves when he left for work and sanitized all equipment at the restaurant before touching it, fearful that he'd carry the virus home to his 9-year-old daughter, who has asthma.

Then last Friday, he learned that the restaurant was shutting its doors, even for takeout.

"I'm in shock," said Juan, who asked that only his first name be used because of his immigration status. "I was kind of afraid to go to work, but now I don't know what to do."

Others say their undocumented status prevents them from demanding protective equipment as they continue to go about their jobs.

An undocumented farmworker in northern Ohio, who spoke on the condition of anonymity for fear of losing her $10 an hour job, said she has been planting tomatoes, onions and other produce — without the protectiou of gloves and masks and without access to soap and running water.

The 36-year-old farmworker, who came to the U.S. from Monterrey, Mexico, when she was 15, brings her own liquid soap from home and uses drinking water to wash her hands during breaks.

She works alongside migrant workers who live in crowded quarters at a labor camp and who she fears wear the same dirty clothes all week because they don't have laundry facilities on site.

The county health department has instructed the farmworkers to work six feet apart -- an edict she says is impossible to follow when they unload plants from the trailers to bring into the nurseries. For one week, her employer took workers' temperatures. But no longer.

The mother of four follows a strict routine when she returns from work — removing her shoes outside, washing her clothes daily, and not allowing her children to hug her until she's taken a shower "because I'm not sure if I have the virus or not."

The backdrop for many of the undocumented is the fear of deportation — despite a recent commitment from Immigration and Customs Enforcement to halt most enforcement during the coronavirus outbreak, especially near health-care facilities.

"That provides little comfort," said Anu Joshi, vice president of policy at the New York Immigration Coalition. "ICE field offices have a lot of leeway in moments of crisis to implement their own prioritization rules."

Others worry about jeopardizing their chances to gain permanent status in the U.S. The administration implemented a rule in February that would make it more difficult for low-income immigrants, including those who entered the country legally, to become permanent residents if they have received public benefits, including health coverage for the poor such as Medicaid. But it recently made an exception for those seeking medical attention for the coronavirus.

The most terrifying part of Lydia Nakiberu's day has become her two-hour commute -- on two trains and a bus -- to her job as a home health aide outside Boston.

She shoves her hands in her pockets so as not to touch anything, wears a mask, scrubs her hands every chance she gets — but worries about spreading the virus to the 86-year-old man she cares for. Or to her family.

"They tell us, 'When you get sick, you have to go to the hospital,' but all the undocumented domestic workers I know are so scared that ICE might get their information and come for them," said Lydia, 41, who does not have health insurance.

Both Lydia and her husband, Jerry, are undocumented immigrants from Uganda who have raised their children — ages 13, 12 and 8 — in the United States. Jerry spent three months in an immigration detention center in 2012 after losing an asylum case and missed the birth of his youngest son.

At the nursing home where Jerry works as a nurse, masks are rationed, with caregivers allotted just one for the entire day. They have gloves, but no protective gowns. He thinks the government should be doing more to help workers on health care's front line -- even if they are not authorized to work.

"They need us more than ever before," said Jerry, 54.

Perhaps when this is all over, he said, the American public will recognize how undocumented immigrants risked their lives to help during a time of crisis. In another burst of optimism, he said he hopes that the government would grant legal status to parents of U.S. citizens and other immigrants who have long paid taxes.

But until then, Lydia said: "We are scared about the virus. We are scared about ICE. We are scared about almost everything right now."

Tracy Jan
Tracy Jan covers the intersection of race and the economy for The Washington Post, a beat she launched in December 2016. She previously was a national political reporter at the I

Williams, Victoria (County Judge's Office)

From: James Williams <jastaswillias@gmail.com>
Sent: Thursday, April 23, 2020 3:58 PM
To: Williams, Victoria (County Judge's Office)
Subject: Support for Emergency Financial Assistance funds proposal

I am writing in support of the use of Emergency Financial Assistance funds for a rapid response to help those ineligible for other more immediate assistance. I was offended to hear that families with at least one person without a Social Security number would also not be eligible for COVID-19 Relief funds from our Republican government. Anything we can do to offset this misguided and unfair situation should be done. If any person is being cut-off for having at least one person without a SSN in their household is being deemed guilty by association. This is inherently wrong. I am grateful that the Ryan White Program is there to make things better for at least some suffering from this injustice.

-- James Thomas Williams

April 23, 2020

To: Ryan White Office of Support

From: Latino HIV Task Force

Latino HIV Task Force (LHTF) would like to express its concerns about how the Covid-19 has impacted the Latino community.

Harris County as a whole has 43% Hispanic, 29% White, 20% African American, and 7% Asian in population composition.

The Covid-19 breakdown as of April 21, 2020 is 25% Hispanic, 23% African American, 18% White, 4% Asian and 1% other.

As the Covid-19 continues to spread across Harris County and the City of Houston, the Latino communities are among those who will continue to be disproportionally affected by the virus. Barricading access to governmental programs; services; and benefits through means of discrimination on the basis of immigration status, socio-economic status, race, color, age, gender identification and sexual orientation will further exacerbate health and economic inequities.

Latino Children are affected by the following supportive services received by school districts. Many children will be impacted by lack of nutritional supplements provided by the school. They will suffer due to unavailable free lunch programs. Many children and youth access school facilitated health care, for vaccinations and mental health services. Children ages 5 – 17 years old will miss the WHO recommendation of 60 minutes a day of moderate-to-vigorous physical activities. This will increase their risk of establishing bad habits like increased TV or Video Games or other electronics' use. But also, snacking that can damage future cardiovascular and musculoskeletal health. In addition, the current situation impacts the health of our children and youth who suffer from living with HIV. Many of these children did not have the tools needed to complete their school-work because of the lack of internet access and most importantly their lack of laptops, computers or tablets.

Adolescents are impacted because of school closures and social distancing is challenging. Adolescents at this age are growing independent and begin to prioritize connections with peers over parents. They may grieve their rites of passage they were due to experience, like proms and graduations. Anxiety could increase in adolescents as they try to understand the Covid-19 pandemic.

In general, Latino seniors tend to seek less medical and counseling help than African-American and Anglo seniors do. Fearful of government policies with regard to the Latino communities, especially immigrants, they avoid dealing with governmental agencies and CBOs that might report them to immigration authorities. This reluctance to seek help is especially true for the undocumented, or those with undocumented family members. Many Latino seniors serve as the backbone of their families, caring for grandchildren and other children in their community while schools are closed; and these children may have been infected, which puts them at a higher risk of infection themselves. If these seniors become infected and do not get the help they need, the entire family structure will be disrupted, with huge social and financial repercussions to the greater society. This is why getting this financial aid is so very urgent.

Many in the Latino communities are ineligible for unemployment insurance or the $1,200 stimulus check that the government just released. Our undocumented are unable to rely on the government's relief aid, some despite having paid taxes and living in the U.S. for more than two decades. If they are stricken with the Covid-19, they will question whether to seek medical attention because of facing deportation, or being separated from family. If they are not faced with being undocumented, many work as cooks, cleaners, janitors, industries which have been hit the hardest by the pandemic. The majority of this group do not have health insurance or are under insured. If living with HIV, many can access Ryan White Services. These will not cover loss of wages, or some high medical bills associated with treatment due to this Pandemic.

Many of our agencies have reached their limits in assisting clients with rental and utilities assistance. Transportation, while always a barrier, continues to be as such with the added dangers of acquiring COVID-19 from the need to use public transportation. Metro reports an increase of COVID-19 diagnoses for bus drivers, Quality Assurance staff, bus cleaners, etc. Access to Food Pantry has been challenging to more families than usual.

The Emergency Financial Assistance service category provided by Ryan White with COVID-19 Relief Funds, while a great help if no restrictions are put in place, will not assist the Latino community if they continue to uphold restrictions that discriminate and will be a tremendous negative impact on our communities if they do. But, if this category is created to provide a more equitable situation for those ineligible for other financial assistance, and maintains the flexibility and agility to respond quickly, then we will have finally created a financial relief category which truly serves ALL people with HIV in our area, including immigrants of undocumented status and the families which include them.

Gloria Sierra, Chair

Steven Vargas, Co-Chair

Richard Gamez, Secretary

PUBLIC COMMENT – as of 04-15-20

From: Steven Vargas <sivargas68@yahoo.com>
Sent: Wednesday, April 15, 2020 12:28 PM
To: Williams, Victoria (County Judge's Office); Martin, Carin (PHS); Tana Brown; Barr, Melody - HCD
Subject: Fwd: Coronavirus eviction rules don't always help people in motels

This is something I was thinking an emergency response fund could address and help alleviate.

I hope to be proven wrong, but I don't think HOPWA's STRUMA or TBRA programs would be able to assist in such cases.

Back in in 2006-2008, the Ryan White Program did fund temporary stays in motels for those returning to society from incarceration. This made it easier to assist with accessing medical care and more stable housing. At the time, PC members thought HOPWA would be able to do something similar and supplant those funds and recreate something similar.

I see similar functions for such funds for:

1. PWH returning from incarceration,

2. PWH needing temporary stay away from home due to something like COVID, whether the PWH needs isolating or need to be somewhere away from home where someone in their home has COVID or something similar

3. PWH needing a temporary stay if home is unlivable due to a fire or other disaster (hurricane, tornado, flood, infestation)

I have worked at two Houston ASOs and both have had to fund such stays for PWH during my tenure with them. Sometimes the agency had to use general funds to do so to address the need in a timely and useful fashion.

---------- Forwarded message ---------
From: **Stateline Daily** <outreach@pewtrusts.org>
Date: Wed, Apr 15, 2020, 11:31 AM
Subject: Coronavirus eviction rules don't always help people in motels
To: <sivargas68@yahoo.com>

View in web browser

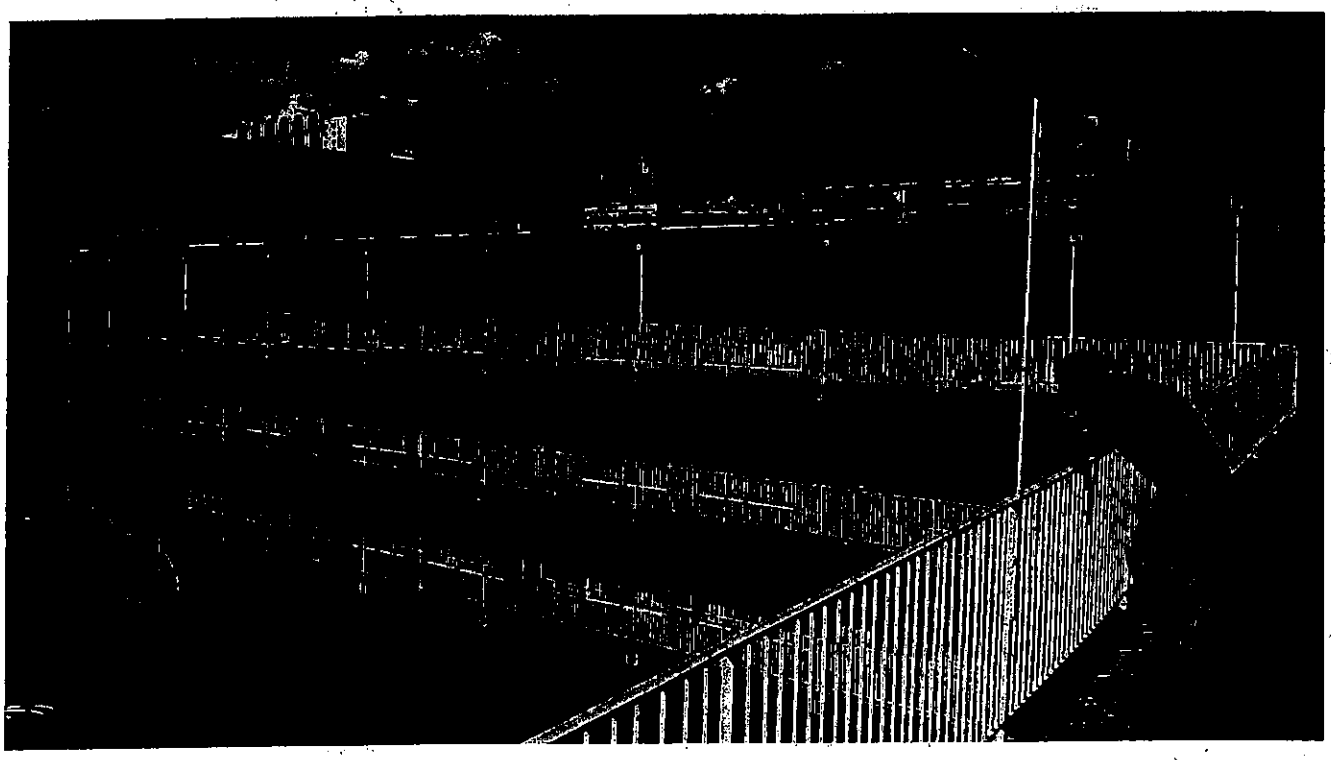
PEW

Stateline Daily

Stateline

Coronavirus Eviction Rules Don't Always Help People in Motels

STATELINE ARTICLE April 15, 2020 By: Teresa Wiltz Topics: Business of Government & Health Read time: 5 min



A man stands outside of his Reno, Nevada, motel room before the pandemic. Many families and individuals living in extended-stay motels are facing eviction during the pandemic.

John Locher/The Associated Press

Read *Stateline* coverage of the latest state action on coronavirus.

For the past few months, Stefanie Craft, her five kids and two pets, a cat and a dog, have been camped out in the Economy Inn and Suites in North Charleston, South Carolina. It wasn't her first choice: Black mold crawling up the walls of their rental house forced her hand.

Still, it's home, for now, so they're riding out the pandemic in one room with a "sink-sized kitchen."

Now Craft, 44, who says she has always paid her $325 weekly motel rent on time, is facing eviction. She lost her job supervising a local car wash when the coronavirus shuttered her city. A local church paid her rent this week, she said, but she's terrified about what will happen next. The motel's manager could not be reached for comment about Craft's case.

"I have no clue what I'm going to do," Craft told *Stateline* in a telephone interview. "We have nowhere to go. That's why we're here."

States have reached different conclusions.

This month, North Carolina Attorney General Josh Stein, a Democrat, ordered local motels and hotels to stop threatening to evict tenants during the pandemic.

Hotels have been devastated by the pandemic, said Lynn Minges, president and CEO of the North Carolina Restaurant and Lodging Association. Eight out of 10 hotels in the state either were forced to close or are operating at less than 20% capacity, she said, adding that many are sheltering homeless families and individuals.

"We're clear that it is unlawful for a hotel to evict a guest if that is how they are finding shelter," Minges said. "They are still responsible for the payment of those rooms," but those are matters that can be resolved later, she said.

In neighboring South Carolina, however, the state's April no-eviction order does not apply to people living in motels.

And sometimes states and localities don't agree. In Michigan, for example, tenant protection laws do not cover motel residents.

But after Kent County, Michigan, motels evicted more than a dozen families and threatened to evict roughly 75 more last month, local officials got involved, said Casey Gordon, who works with homeless students and families for the Kent County Intermediate School District.

County officials, Grand Rapids city administrators and the county public health department told motel owners that they were essential businesses and evicting residents would violate the local eviction moratorium, Gordon said.

But many motels shut down anyway and kicked families out, according to Gordon, and some families ended up in shelters. Others are living in "doubled-up situations," couch-surfing with friends. Some ended up in other motels.

"It's getting really difficult," Gordon said. "Hotels are saying, 'We can't continue to provide staffing. People aren't coming into work.'"

In some places, evictions are happening at the same time that cities, in an effort to protect people who experience chronic homelessness, are commandeering empty motels to house them.

Many federal agencies, such as the U.S. Department of Education, consider people to be homeless if they're living in hotels or motels. But there are no clear statistics tracking this population.

Motel residents are a difficult population to pin down because they live in a motel when they can afford it and when they can't they often move to their cars or a friend's couch. Nor

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U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-7000

OFFICE OF COMMUNITY PLANNING
AND DEVELOPMENT

May 22, 2020

MEMORADUM FOR: All Community Planning and Development Field Office Directors, Deputy Directors and Program Managers

FROM: John Gibbs, Assistant Secretary, Acting, D

Digitally signed by JOHN GIBBS
Date: 2020.05.22 12:33:10 -04'00'

SUBJECT: Availability of Additional Waivers for Community Planning and Development (CPD) Grant Programs to Prevent the Spread of COVID-19 and Mitigate Economic Impacts Caused by COVID-19

PURPOSE

This memorandum explains the availability of waivers of certain regulatory requirements and one NOFA requirement associated with several CPD grant programs to prevent the spread of COVID-19 and to facilitate assistance to eligible communities and households economically impacted by COVID-19. This memorandum covers program-specific waivers for the following CPD programs:

- Housing Opportunities for Persons with AIDS (HOPWA);
- Continuum of Care (CoC);
- Youth Homelessness Demonstration Program (YHDP); and
- Emergency Solutions Grants Program

This memorandum also announces a simplified notification process for recipients of these programs to use this waiver flexibility to expedite the delivery of assistance. CPD Field Office Directors, Deputy Directors, and Program Managers are instructed to inform CPD recipients operating within their jurisdictions of the content of this memorandum.

NOTIFICATION PROCESS

Recipients may use the waivers described in this memorandum to assist affected CPD program beneficiaries and CPD program eligible households to prevent the spread of COVID-19 and to mitigate against the economic impact caused by COVID-19 for eligible households. To use the waiver flexibility provided in this memorandum, the recipient must provide notification in writing, either through mail or e-mail, to the CPD Director of the HUD Field Office serving its jurisdiction no less than two days before the recipient anticipates using the waiver flexibility. Further directions on notifying HUD can be found in Attachment #1.

WAIVER AUTHORITY

In December 2019, a new coronavirus known as SARS-CoV-2 was first detected in Wuhan, Hubei Province, People's Republic of China, causing outbreaks of the coronavirus disease COVID-19 that has now spread globally. The first case was reported in the United States in January 2020. In March 2020, the World Health Organization declared the coronavirus outbreak a pandemic and President Trump declared the outbreak a national emergency. During this time, the majority of states have declared states of emergency with most shutting down large gathering places and limiting the movement of their residents. As a consequence, many CPD recipients are facing challenges in ensuring appropriate shelter options are available for program participants who need to be separated from others because they are exhibiting symptoms, training staff on how to safely work with program participants and prevent spreading the virus, obtaining supplies to prevent the spread of the virus, and maintaining necessary staffing levels during the outbreak. Further, many program participants are suffering economic consequences from the mass shutdown of businesses and lack of availability of traditional mainstream benefits. A number of recipients have inquired about the availability of waivers of various CPD program requirements to facilitate assistance to program participants and prevent the spread of the virus.

In accordance with 24 CFR 5.110, HUD may, upon a determination of good cause and subject to statutory limitations, waive regulatory provisions. Additional regulatory waiver authority is provided in 24 CFR 91.600. On March 31, 2020, CPD issued its first waivers of regulatory authority to help recipients prevent and mitigate the spread of COVID-19. This memorandum includes additional waivers for the ESG, CoC, YHDP, and HOPWA Programs.

WAIVER AVAILABILITY

To provide additional flexibility to communities to prevent the spread of COVID-19 and better assist individuals and families, including those experiencing homelessness infected with the virus or economically impacted by the virus, I hereby find good cause to provide the regulatory waivers below. To use each waiver, each recipient must follow the notification process described above and update its program records to include written documentation of the specific conditions that justify the recipient's use of the waiver, consistent with the justifications and applicability provisions below. Provisions that are not specifically waived remain in full effect.

EMERGENCY SOLUTIONS GRANT PROGRAM

To the extent that funding provided under the CARES Act for the ESG program is subject to the same requirements in 24 CFR part 576 that apply to ESG funding provided through annual appropriations, the waivers made available on March 31, 2020 for ESG are made available with respect to the CARES Act funding for the same justifications and subject to the same conditions.

Additionally, the following housing stability case management waiver is made available with respect to all ESG grants, whether funded under the CARES Act or annual ESG appropriations.

1. Housing Stability Case Management

Requirement: Program participants receiving homelessness prevention or rapid re-housing assistance must meet with a case manager not less than once per month, unless certain statutory prohibitions apply.

Citation: 24 CFR 576.401(e)

Explanation: Under 24 CFR 576.401(e), the recipients or subrecipients must require program participants to meet with a case manager not less than once per month to assist them in ensuring long-term housing stability, unless the Violence Against Women Act of 1994 or Family Violence Prevention and Services Act prohibits the recipient or subrecipient from making its shelter or housing conditional on the participant's acceptance of services. As provided by the CARES Act, people experiencing homelessness cannot be required to receive treatment or perform any other prerequisite activities as a condition for receiving shelter, housing, or other services funded with ESG grants provided under the CARES Act. Accordingly, 24 CFR 576.401(e) does not apply to the extent the assistance is provided with CARES Act funding to people who qualified as homeless at the start of that assistance.

Justification: HUD originally waived this requirement for 2-months on March 31, 2020. Recipients are continuing to report limited staff capacity as staff members are home for a variety of reasons related to COVID-19 (e.g., quarantining, children home from school, working elsewhere in the community to manage the COVID-19 response). In addition, not all program participants have capacity to meet via phone or internet. Waiving the monthly case management requirement as specified below will allow recipients to provide case management on an as needed basis and reduce the possible spread and harm of COVID-19.

Applicability: This waiver is in effect for an additional three months beginning on the date of this memorandum.

CONTINUUM OF CARE PROGRAM and YOUTH HOMELESSNESS DEMONSTRATION PROGRAM

To the extent YHDP grants are subject to the same requirements in 24 CFR part 578 that apply to grants provided under the CoC Program, the same waivers made available on March 31, 2020 for grants provided under the CoC Program are made available to YHDP grants for the same justifications and subject to the same conditions. Additionally, the following waivers are available to CoC Program and YHDP recipients.

2. Permanent Housing Rapid Re-housing Limit to 24 Months of Rental Assistance

Requirement: CoC Program funds may be used to provide short-term (up to 3 months) and/or medium-term (for 3 to 24 months) tenant-based rental assistance.

Citation: 24 CFR 578.37(a)(1)(ii), 24 CFR 578.37(a)(1)(ii)(C), and 24 CFR 578.51(a)(1)(i)

Explanation: The CoC Program regulation at 24 CFR 578.37(a)(1)(ii) and 24 CFR 578.51(a)(1)(i) defines medium-term rental assistance as 3 to 24 months and 578.37(a)(1)(ii) and 24 CFR 578.37(a)(1)(ii)(C) limits rental assistance in rapid re-housing projects to medium-term rental assistance, or no more than 24 months.

Justification: Waiving the limit on using rental assistance in rapid re-housing projects to pay more than 24 months will ensure that individuals and families currently receiving rapid re-housing assistance do not lose their assistance, and consequently their housing, during the COVID-19 public health crisis and the subsequent economic downturn. This will reduce the spread and harm of COVID-19 by enabling affected program participants to continue to socially isolate in their housing.

Applicability: The 24-month rental assistance restriction is waived for program participants in a permanent housing rapid re-housing project who will have reached 24 months of rental assistance beginning on the date of this memorandum until a state or local public health official has determined special measures are no longer necessary to prevent the spread of COVID-19. Program participants who have reached 24 months of rental assistance during this time and who will not be able to afford their rent without additional rental assistance will be eligible to receive rental assistance until 3 months after a state or local public health official has determined that special measures are no longer necessary to prevent the spread of COVID-19.

3. Limit to be Eligible for DedicatedPLUS Project When Coming from Transitional Housing Being Eliminated

Requirement: To be eligible for a DedicatedPLUS project an individual or family must meet the criteria of DedicatedPLUS in the Notice of Funding Availability under which the grant was awarded. One of the possible criteria is residing in transitional housing *that will be eliminated* and meeting the definition of chronically homeless in effect at the time in which the individual or family entered the transitional housing project.

Citation: Section III.C.3.f.(2) of the FY 2018 CoC Program Competition NOFA and Section III.C.2.g.(2) of the FY 2019 CoC Program Competition NOFA.

Explanation: Section III.C.3.f.(2) of the FY 2018 CoC Program Competition NOFA and Section III.C.2.g.(2) of the FY 2019 CoC Program Competition NOFA

define a DedicatedPLUS project as a PSH project where 100 percent of the beds are dedicated to serve individuals and families residing in one of six places at intake, including residing in a transitional housing project that will be eliminated.

Justification: Waiving the requirement within the definition of DedicatedPLUS project that the transitional housing project is being eliminated will expand permanent housing options available for people moving out of transitional housing and will make more transitional housing beds available to others who need it. Expanding permanent housing options for persons in transitional housing will assist in preventing the spread of COVID-19 by allowing more people to move off the streets and into transitional housing.

Applicability: The definition of DedicatedPLUS project is waived for DedicatedPLUS projects funded in the FY 2018 and FY 2019 CoC Program Competitions to allow these projects to serve individuals and families residing in transitional housing, whether it is being eliminated or not, as long as the individual or family met the definition of chronically homeless upon entry to the TH.

4. Assistance Available at Time of Renewal

Requirement: With respect to renewing CoC Program awards, 24 CFR 578.33(c) requires that assistance for a renewal period will be up to 100 percent of the amount available for supportive services and HMIS costs in the final year of the prior funding period, up to 100 percent of the amount for leasing and operating in the final year of the prior funding period adjusted in proportion to changes in FMR for the geographic area, and for rental assistance up to 100 percent of the result of multiplying the number and unit size(s) in the grant agreement by the number of months in the grant agreement and the applicable FMR.

Citation: 24 CFR 578.33(c)

Explanation: 24 CFR 578.33(c) requires that budget line item amounts a recipient is awarded for renewal in the CoC Program Competition will be based on the amounts in the final year of the prior funding period for the project.

Justification: Waiving the requirement that the renewal grant amount is based on the budget line items in the final year of the grant being renewed will allow recipients to amend their budgets temporarily to address the needs of its program participants in responding to COVID-19 (e.g., providing different supportive services necessitated by the pandemic or serving fewer people because of the layout of the housing does not meet local social distancing recommendations) without changing the original design of the project when it is not operating in a public health crisis and can resume normal operations.

Applicability: The requirement that the renewal grant amount be based on the budget line items in the final year of the grant being renewed is waived for all projects that amend their grant agreement between March 31, 2020 and October 1, 2020 to move funds between budget line items in a project in response to the COVID-19 pandemic. Recipients may then apply in the next FY CoC Program Competition based on the budget line items in the grants before they were amended.

Notification: Recipients utilizing this waiver flexibility do not need to follow the notification process outlined in Attachment #1. Instead, HUD will consider any grant agreement amendment executed between March 31, 2020 and October 1, 2020 to move funds between budget line items in response to the COVID-19 pandemic as notification to HUD.

5. Permanent Housing-Rapid Re-housing Monthly Case Management

Requirement: Recipients must require program participants of permanent housing – rapid re-housing projects to meet with a case manager at least monthly.

Citation: 24 CFR 578.37(a)(1)(ii)(F)

Explanation: The CoC Program interim rule at 24 CFR 578.37(a)(1)(ii)(F) requires program participants to meet with a case manager not less than once per month to assist them in ensuring long-term housing stability. The project is exempt from this requirement already if the Violence Against Women Act of 1994 (42 U.S.C. 13925 *et seq.*) or the Family Violence Prevention and Services Act (42 U.S.C. 10401 *et seq.*) prohibits the recipient carrying out the project from making its housing conditional on the participant's acceptance of services.

Justification: HUD originally waived this requirement for 2-months beginning March 31, 2020. Recipients are continuing to report limited staff capacity as staff members are home for a variety of reasons related to COVID-19 (e.g., quarantining, children home from school, working elsewhere in the community to manage the COVID-19 response). In addition, not all program participants have capacity to meet via phone or internet. Waiving the monthly case management requirement as specified below will allow recipients to provide case management on an as-needed basis and reduce the possible spread and harm of COVID-19.

Applicability: This requirement in 24 CFR 578.37(a)(1)(ii)(F) that projects require program participants to meet with case mangers not less than once per month is waived for all permanent housing- rapid re-housing projects for an additional three months beginning on the date of this memorandum.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

6. HOPWA – Time Limits for Short-Term Housing Facilities and Short-Term Rent,

Mortgage, and Utility Payments

Requirement: Time Limits for Short-Term Supported Housing

Citation: 24 CFR 574.330(a)(1), Time Limits

Explanation: A short-term supported housing facility may not provide residence to any individual for more than 60 days during any six-month period. Short-Term Rent, Mortgage, and Utility (STRMU) payments to prevent the homelessness of the tenant or mortgagor of a dwelling may not be provided for costs accruing over a period of more than 21 weeks in any 52-week period.

Justification: This waiver is required to prevent homelessness or discharge to unstable housing situations for households residing in short-term housing facilities or units assisted with STRMU if permanent housing cannot be achieved within the time limits specified in the regulation.

Applicability: On an individual household basis, grantees or project sponsors may assist eligible households for a period that exceeds the time limits specified in the regulations. A short-term supported housing facility may provide residence to any individual for a period of up to 120 days in a six-month period. STRMU payments to prevent the homelessness of the tenant or mortgagor of a dwelling may be provided for costs accruing up to 52 weeks in a 52-week period.

This waiver is in effect for one year beginning on the date of this memorandum for grantees and project sponsors that are able to meet the following criteria:

a. The grantee or project sponsor documents that a good faith effort has been made on an individual household basis to assist the household to achieve permanent housing within the time limits specified in the regulations but that financial needs and/or health and safety concerns have prevented the household from doing so; and
b. The grantee or project sponsor has written policies and procedures outlining efforts to regularly reassess the needs of assisted households as well as processes for granting extensions based on documented financial needs and/or health and safety concerns.

7. HOPWA – Property Standards

Requirement: Property Standards for HOPWA

Citation: 24 CFR 574.310(b), Housing Quality Standards

Explanation: This section of the HOPWA regulations provides that all housing assisted

with acquisition, rehabilitation, conversion, lease, or repair; new construction of single room occupancy dwellings and community residences; project or tenant-based rental assistance; or operating costs must meet the applicable housing quality standards outlined in the regulations.

Justification: This waiver is required to enable grantees and project sponsors to expeditiously meet the critical housing needs of the many eligible families that have been affected by COVID-19 while also minimizing the spread of coronavirus.

Applicability: This waiver is in effect for one year beginning on the date of this memorandum for grantees and project sponsors that are able to meet the following criteria:

a. The grantee or project sponsor is able to visually inspect the unit using technology, such as video streaming, to ensure the unit meets HQS before any assistance is provided; and
b. The grantee or project sponsor has written policies to physically reinspect the unit after the health officials determine special measures to prevent the spread of COVID-19 are no longer necessary.

8. HOPWA – FMR Rent Standard

Requirement: Rent Standard for HOPWA Rental Assistance

Citation: 24 CFR 574.320(a)(2), Rent Standard

Explanation: Grantees must establish rent standards for their rental assistance programs based on FMR (Fair Market Rent) or the HUD-approved community-wide exception rent for unit size. Generally, the rental assistance payment may not exceed the difference between the rent standard and 30 percent of the family's adjusted income.

Justification: This waiver of the FMR rent standard limit permits HOPWA grantees to establish rent standards, by unit size, that are reasonable, and based upon rents being charged for comparable unassisted units in the area, taking into account the location, size, type, quality, amenities, facilities, management and maintenance of each unit. Grantees, however, are required to ensure the reasonableness of rent charged for a unit in accordance with §574.320(a)(3).

This waiver is required to expedite efforts to identify suitable housing units for rent to HOPWA beneficiaries and HOPWA-eligible families that have been affected by COVID-19, and to provide assistance to families that must rent units at rates that exceed the HOPWA grantee's normal rent standard as calculated in accordance with §574.320(a)(2).

Applicability: Such rent standards may be used for up to one year beginning on the date of this memorandum.

Attachment #1 to Memorandum:

Procedure for Using Available Waivers of Program and Consolidated Plan Requirements to Prevent the Spread of COVID-19 and Mitigate Economic Impacts Caused by COVID-19

This attachment provides further information on the process that grantees must follow to use the waiver flexibility provided in the memorandum.

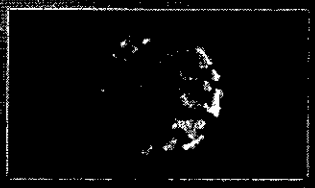
Grantees must email notification to the Community Planning and Development Director of the HUD Field Office serving the grantee.

The email notification must be sent two days before the grantee anticipates using waiver flexibility, and include the following details:

- Requestor's name, title, and contact information;
- Date on which the grantee anticipates first use of the waiver flexibility; and
- A list of the waiver flexibilities the grantee will use:
    1. ESG Program – Housing Stability Case Management
    2. CoC Program and YHDP - Permanent Housing Rapid Re-housing Limit to 24 Months of Rental Assistance
    3. CoC Program NOFA Requirement– Limit to be Eligible for DedicatedPLUS Project When Coming from Transitional Housing (TH) that TH Must be Being Eliminated
    5. CoC – Permanent Housing – Rapid Re-housing Monthly Case Management
    6. HOPWA – Time Limits for Short-Term Housing Facilities and Short-Term Rent, Mortgage, and Utility Payments
    7. HOPWA – Property Standards
    8. HOPWA – FMR Rent Standard

Affected Community Committee Report

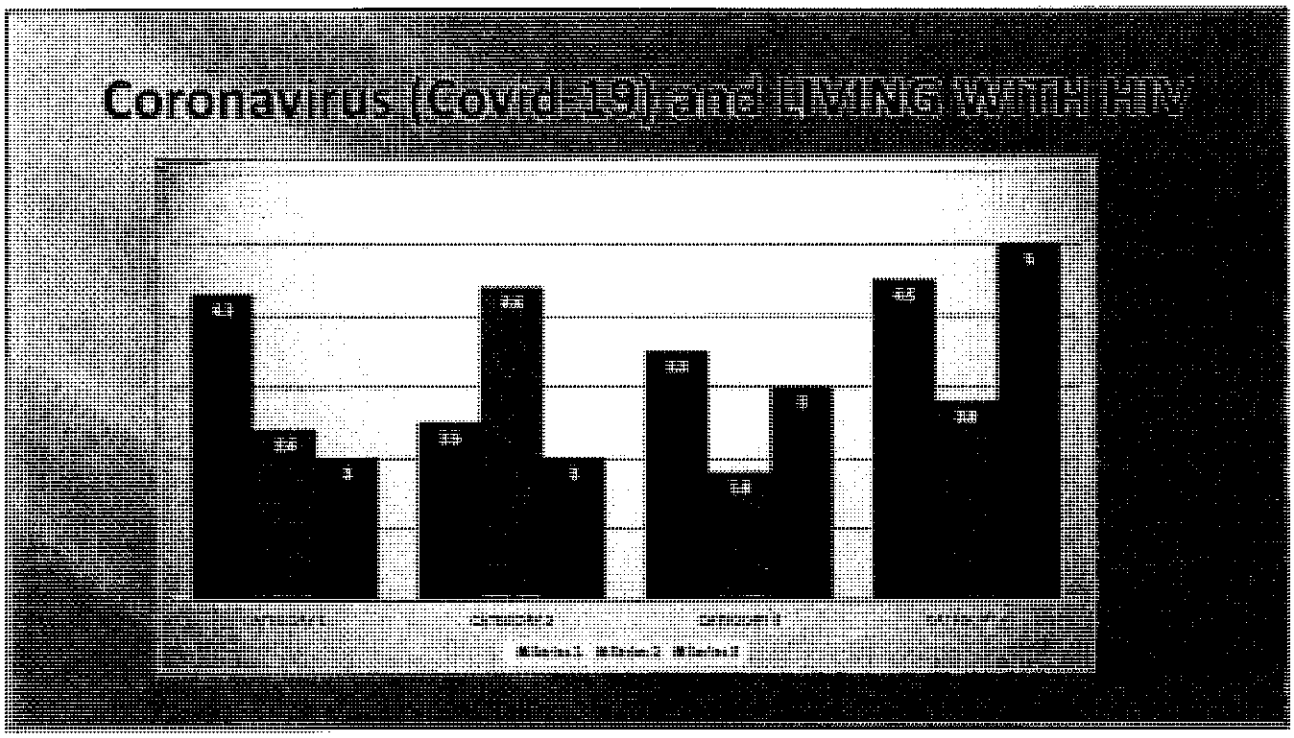
CORONAVIRUS (COVID-19) AND LIVING WITH HIV

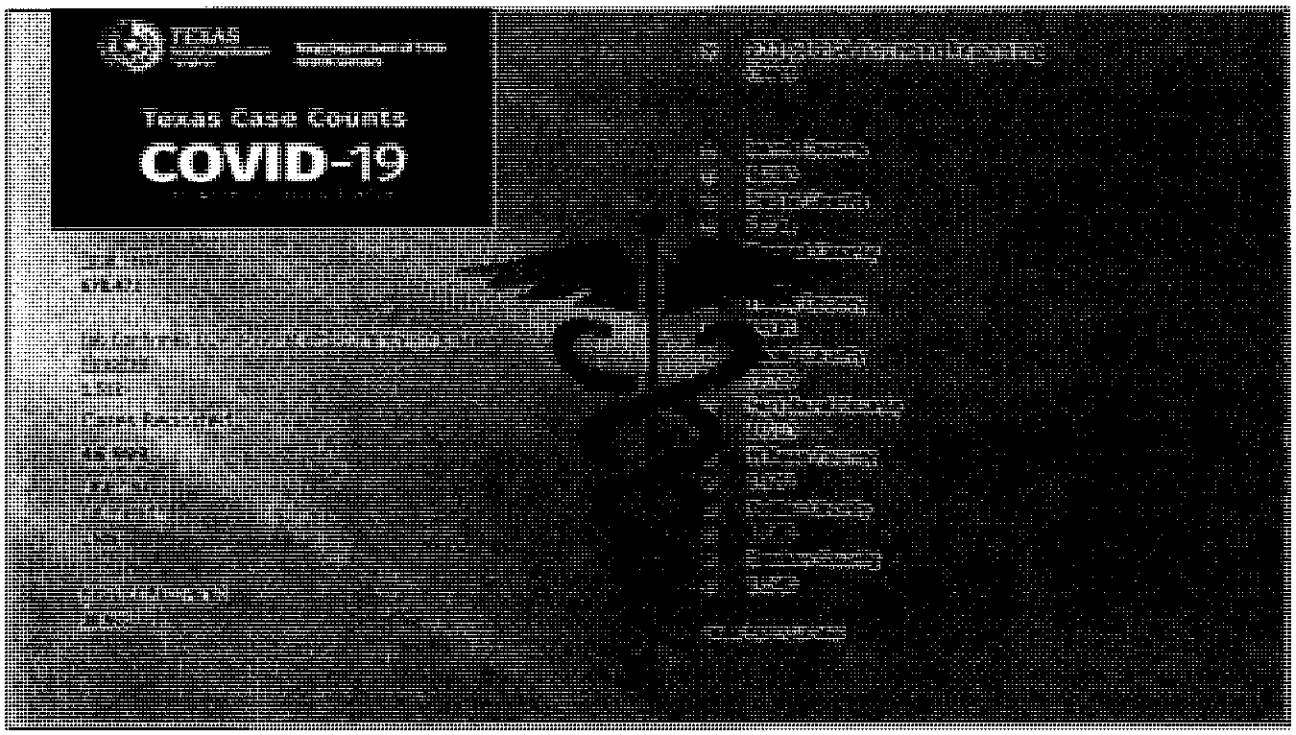


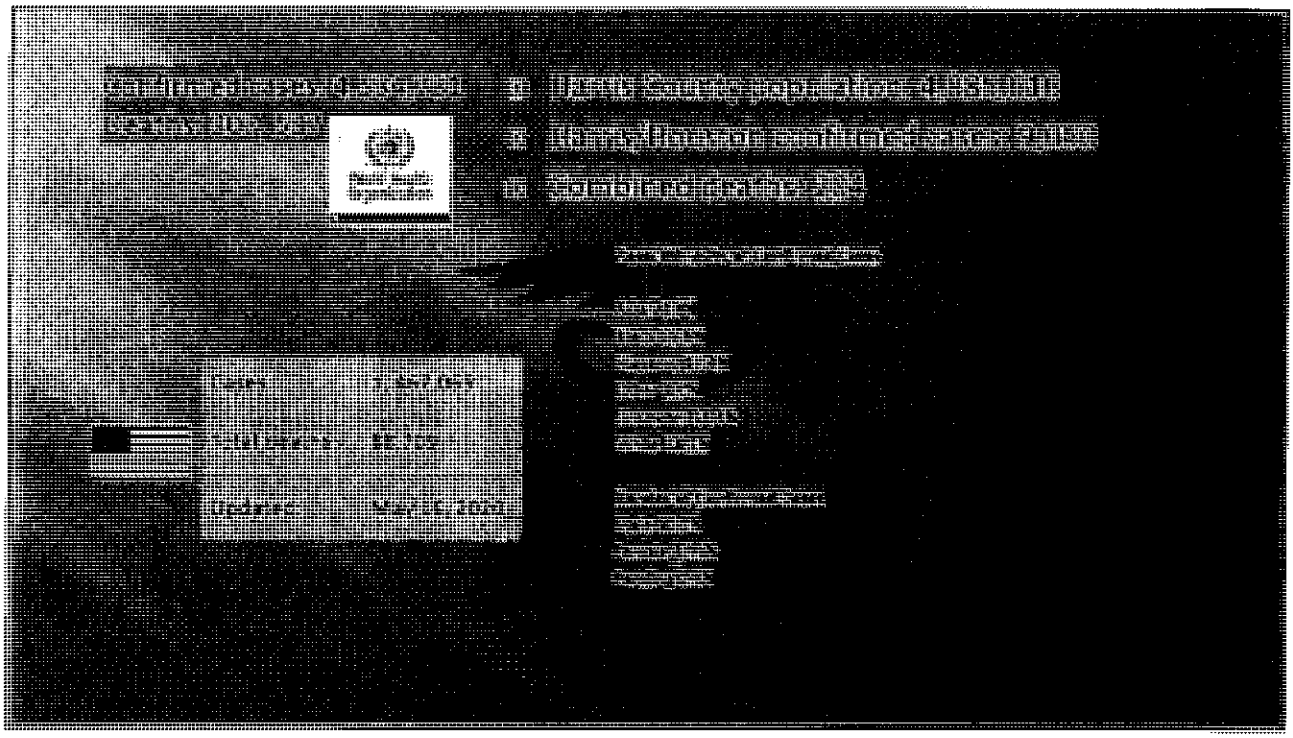
Pete Rodriguez, RN, BSN, AP-RN
Harris County Ryan White Planning Council

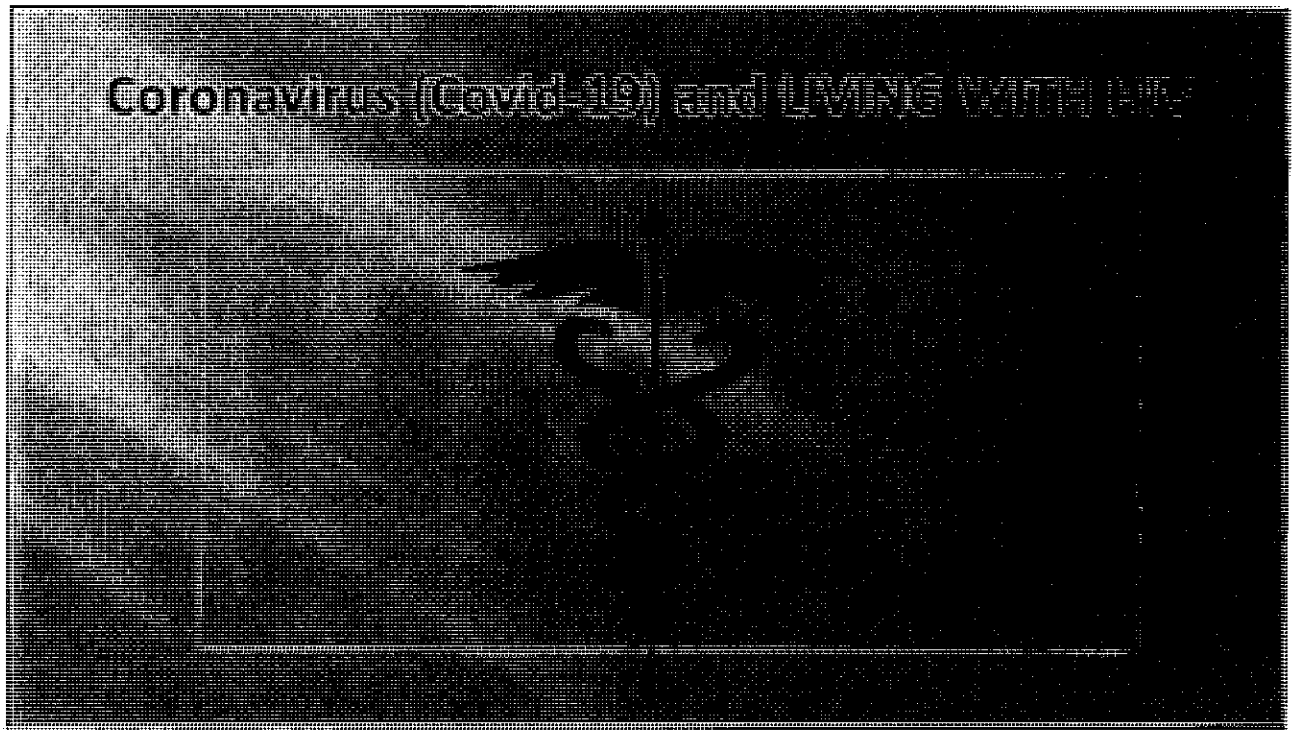
Objectives

- Covid-19 Facts
  - What is it?
  - Symptoms and Treatments
  - Transmission and prevention
- HIV and Covid-19


Coronavirus (Covid-19) and LIVING WITH HIV


Texas Case Counts
COVID-19

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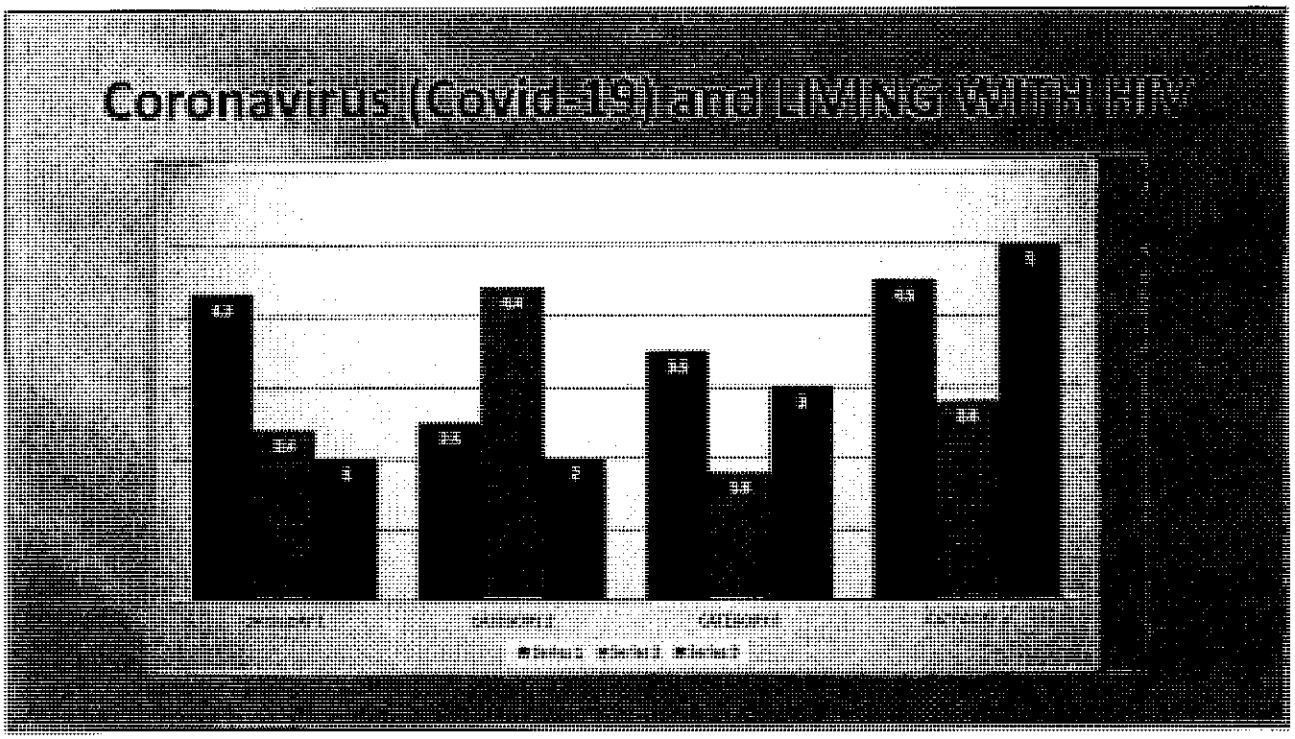
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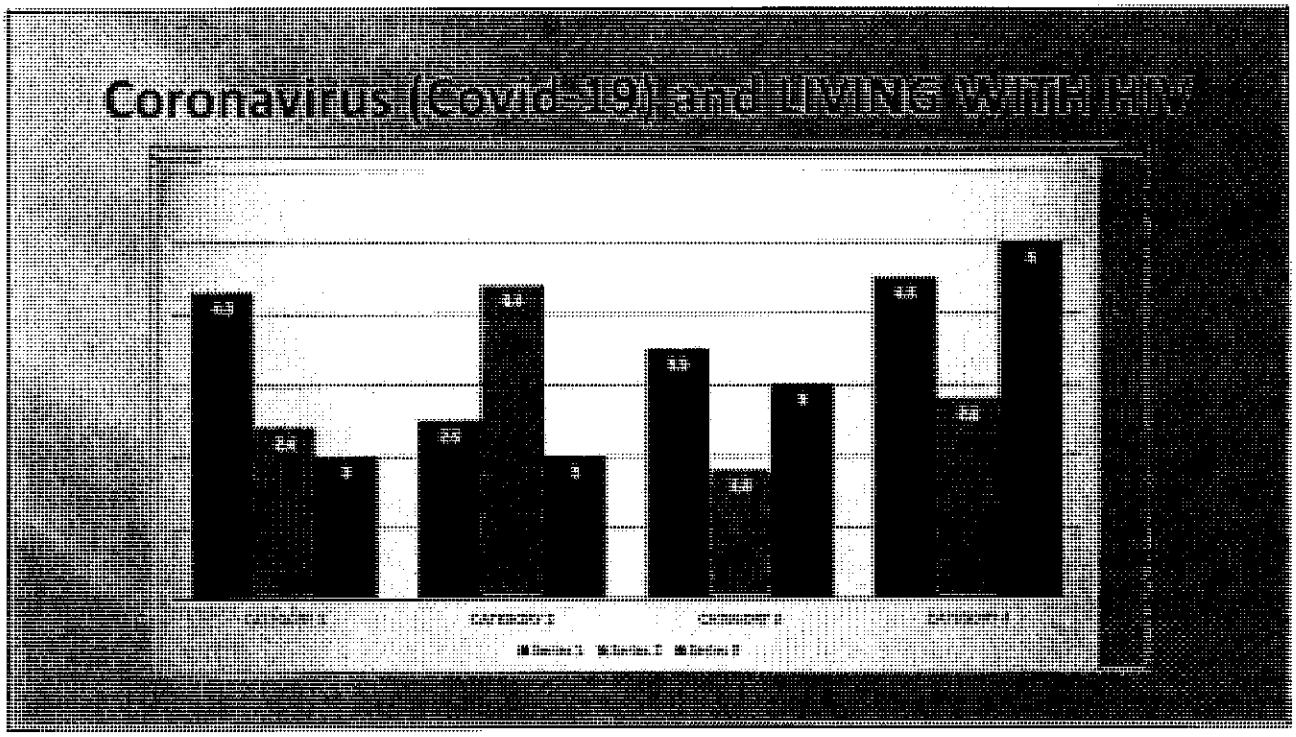
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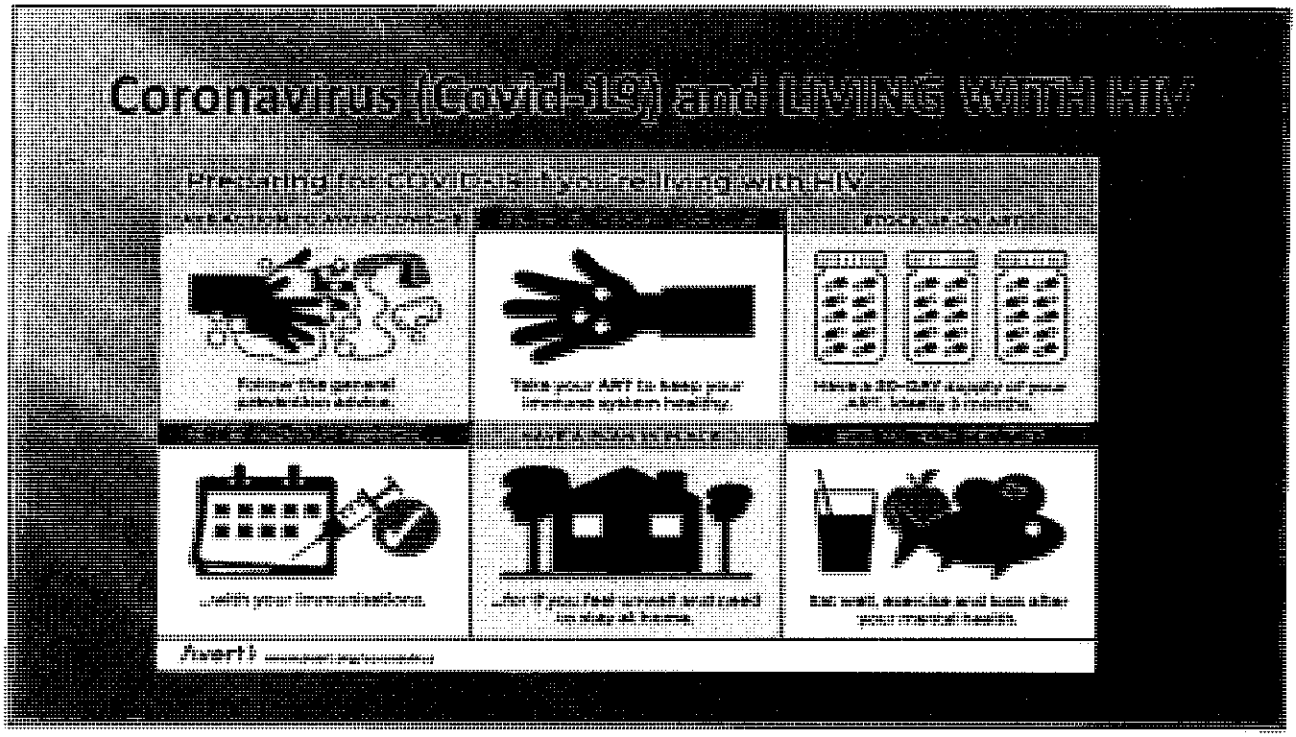
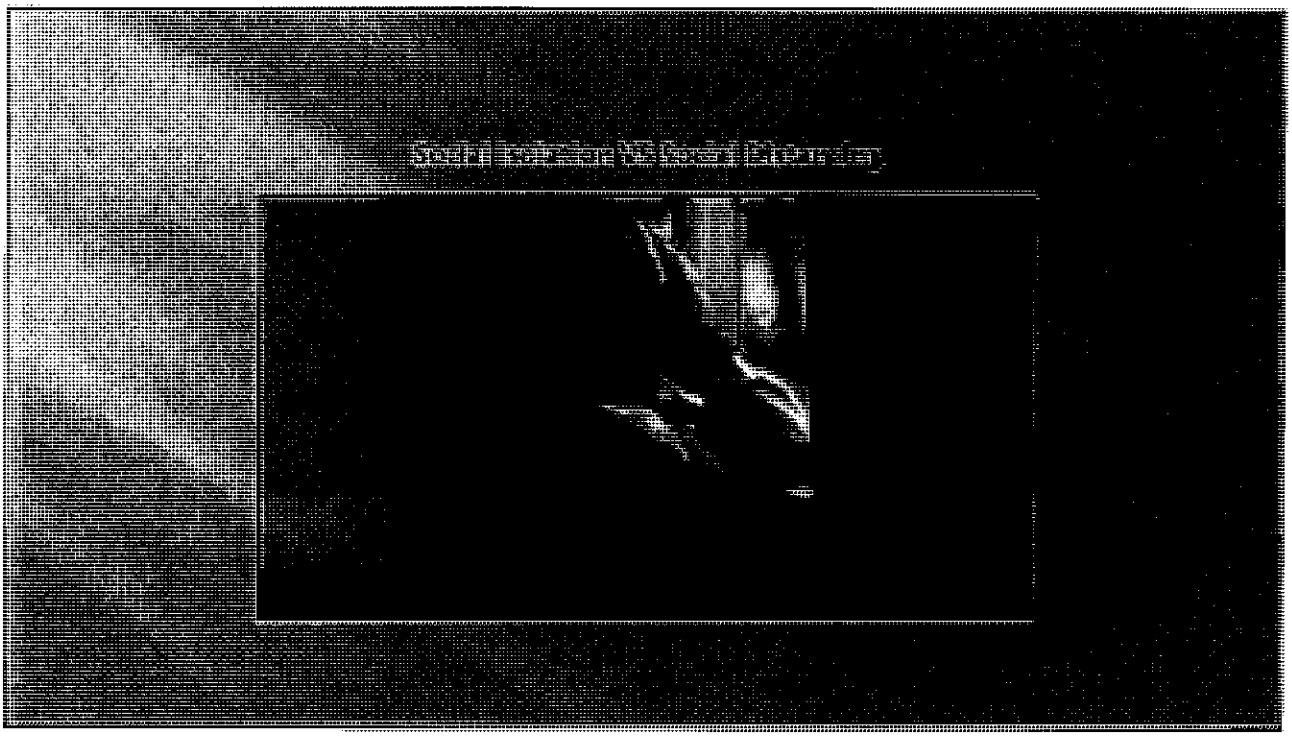
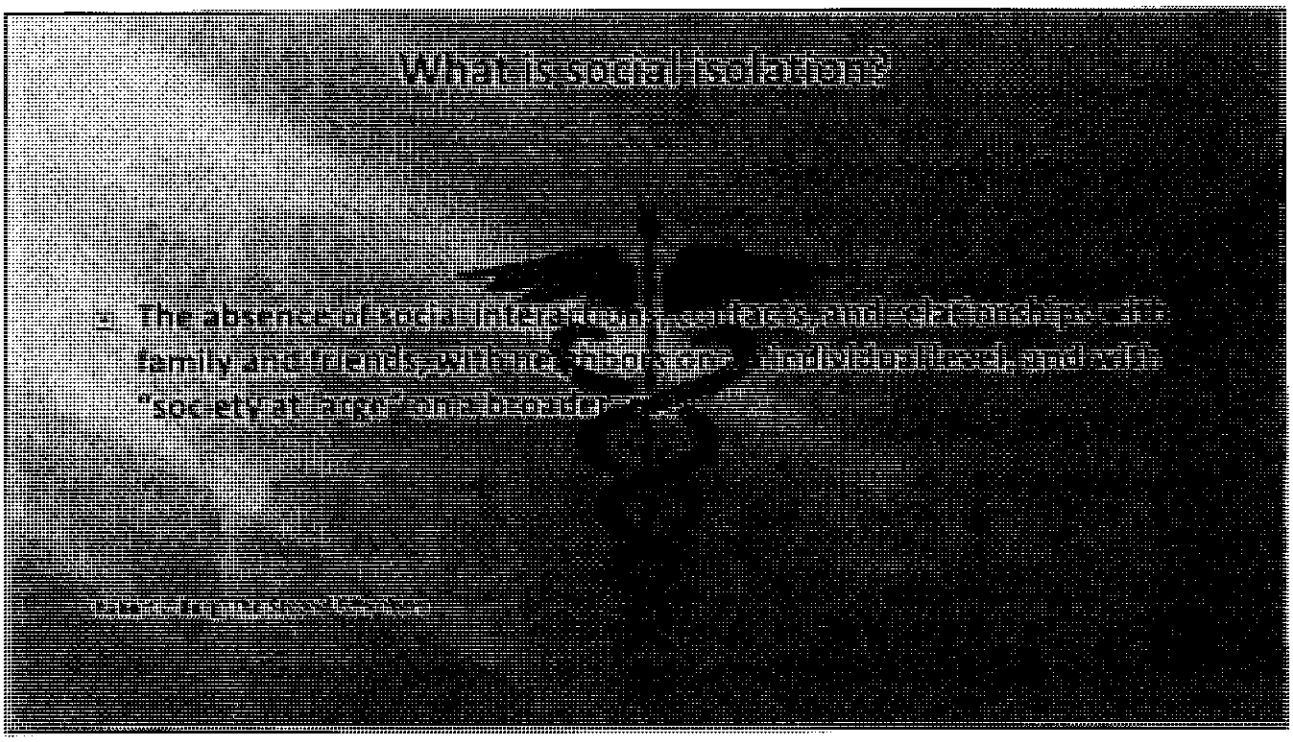

Coronavirus (Covid-19) and LIVING WITH HIV



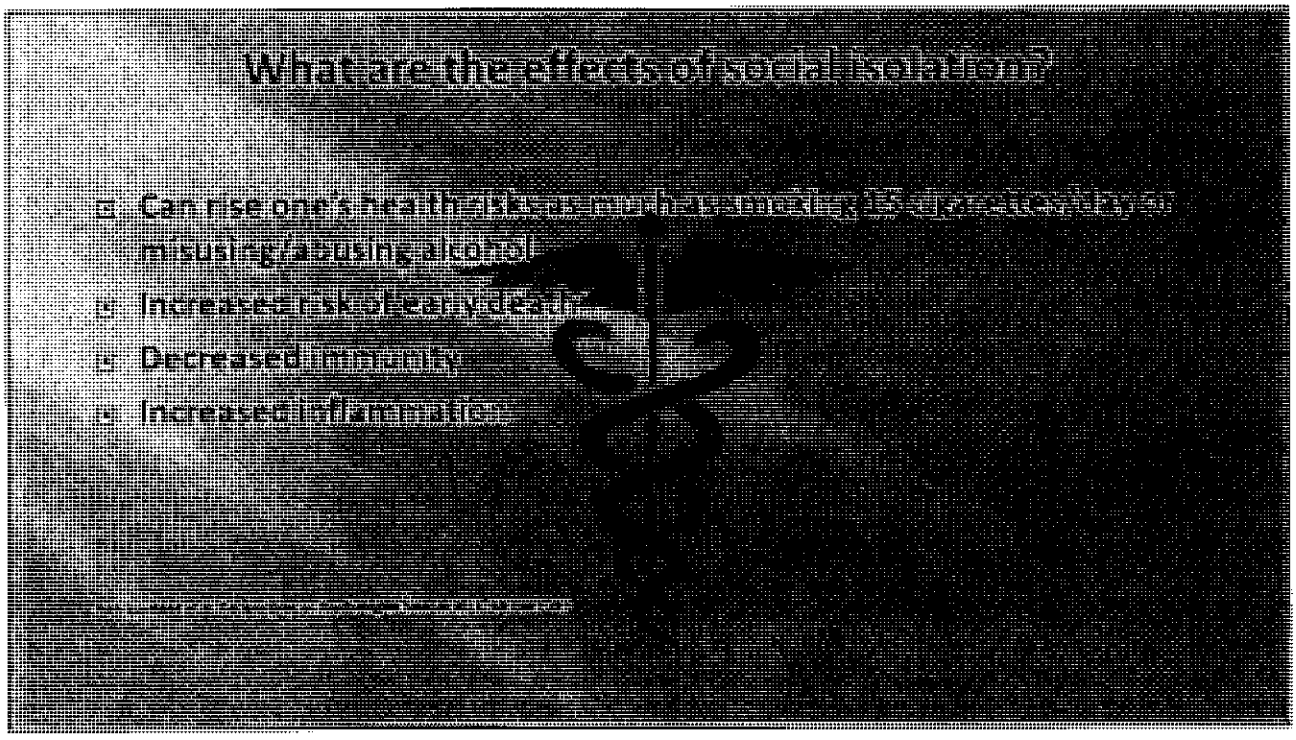
What is social isolation?

- The absence of social interactions, contacts, and attachments with family and friends, with neighbors, with individuals, and with "society at large" one belongs to



What are the effects of social isolation?

- Can rise one's health risks, such as making one more susceptible to misusing/abusing alcohol
- Increased risk of coronary disease
- Decreased immunity
- Increased inflammation



What to do to combat isolation

Questions?

Harris County Public Health
Building a Healthy Community

HOUSTON HEALTH DEPARTMENT

Quality Improvement Committee Report

Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2019 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	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**	**9,783,470**	**0**	**100,096**	**55,000**	**0**	**9,938,566**	**44.29%**	**9,938,566**	**0**	[redacted]	**10,560,011**	**106%**	**100%**
1.a	Primary Care - Public Clinic (a)	3,591,064	0	0	30,000		3,621,064	16.14%	3,621,064	0	3/1/2019	$3,602,340	99%	100%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	25,032	25,000		990,479	4.41%	990,479	0	3/1/2019	$1,355,756	137%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	25,032	0		811,456	3.62%	811,456	0	3/1/2019	$1,337,114	165%	100%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,023,797	0	25,032	0		1,048,829	4.67%	1,048,829	0	3/1/2019	$708,378	68%	100%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,149,761	0	0	0		1,149,761	5.12%	1,149,761	0	3/1/2019	$1,045,332	91%	100%
1.f	Primary Care - Women at Public Clinic (a)	1,874,540	0	0			1,874,540	8.35%	1,874,540	0	3/1/2019	$2,087,591	111%	100%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2019	$9,000	58%	100%
1.h	Vision	402,000	0	25,000	0		427,000	1.90%	427,000	0	3/1/2019	$414,500	97%	100%
2	**Medical Case Management**	**2,535,802**	**0**	**50,000**	**-120,000**	**0**	**2,465,802**	**10.99%**	**2,465,802**	**0**	[redacted]	**1,584,541**	**64%**	**100%**
2.a	Clinical Case Management	488,656	0	0	0		488,656	2.18%	488,656	0	3/1/2019	$488,627	100%	100%
2.b	Med CM - Public Clinic (a)	482,722	0	0	0		482,722	2.15%	482,722	0	3/1/2019	$193,192	40%	100%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	16,666	0		337,736	1.51%	337,736	0	3/1/2019	$254,601	75%	100%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	16,666	0		337,738	1.51%	337,738	0	3/1/2019	$105,281	31%	100%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	16,668	0		123,915	0.55%	123,915	0	3/1/2019	$94,587	76%	100%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0	-60,000		288,760	1.29%	288,760	0	3/1/2019	$226,844	79%	100%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.80%	180,311	0	3/1/2019	$97,999	54%	100%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	-60,000		100,051	0.45%	100,051	0	3/1/2019	$20,562	21%	100%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.36%	80,025	0	3/1/2019	$66,052	83%	100%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.20%	45,888	0	3/1/2019	$36,798	80%	100%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,657,166**	**500,000**	**125,126**	**0**	**0**	**3,282,292**	**14.63%**	**3,282,292**	**0**	3/1/2019	**$1,736,559**	**53%**	**100%**
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.74%**	**166,404**	**0**	3/1/2019	**166,400**	**100%**	**100%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	0	0			166,404	0.74%	166,404	0	3/1/2019	$166,400	100%	100%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,173,070**	**166,000**	**0**	**100,000**	**0**	**1,439,070**	**6.41%**	**1,439,239**	**-169**	3/1/2019	**$1,439,239**	**100%**	**100%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**-10,000**	**0**	**35,677**	**0.16%**	**35,677**	**0**	3/1/2019	**$35,344**	**99%**	**100%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.52%**	**341,395**	**0**	3/1/2019	**$307,128**	**90%**	**100%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**0**				**420,000**	**1.87%**	**420,000**	**0**	**3/1/2019**	**$288,185**	**69%**	**100%**
13	**Emergency Financial Assistance**	**450,000**	**0**	**0**	**0**	**0**	**450,000**	**2.01%**	**450,000**	**0**	**3/1/2019**	**$1,305,439**	**290%**	**100%**
14	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
15	**Non-Medical Case Management**	**1,231,002**	**0**	**100,000**	**-25,000**	**0**	**1,306,002**	**5.82%**	**1,306,002**	**0**	[redacted]	**1,544,450**	**118%**	**100%**
15.a	Service Linkage targeted to Youth	110,793	0	0	-10,000		100,793	0.45%	100,793	0	3/1/2019	$117,714	117%	100%
15.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0		-15,000		85,000	0.38%	85,000	0	3/1/2019	$97,796	115%	100%
15.c	Service Linkage at Public Clinic (a)	427,000	0	0	0		427,000	1.90%	427,000	0	3/1/2019	$522,850	122%	100%
15.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209	0	100,000	0		693,209	3.09%	693,209	0	3/1/2019	$806,091	116%	100%
16	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.89%**	**424,911**	**0**	[redacted]	**424,910**	**100%**	**100%**
16.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.13%	252,680	0	3/1/2019	$281,980	112%	100%
16.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.43%	97,185	0	3/1/2019	$67,884	70%	100%
16.c	Transportation vouchering (bus passes & gas cards)	75,046	0	0	0		75,046	0.33%	75,046	0	3/1/2019	$75,046	100%	0%
17	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
[redacted]	**Total Service Dollars**	**19,228,897**	**666,000**	**375,222**	**0**	**0**	**20,270,119**	**88.46%**	**20,270,288**	**-169**	[redacted]	**19,392,204**	**96%**	**100%**
[redacted]	**Grant Administration**	**1,675,047**	**119,600**	**0**	**0**	**0**	**1,794,647**	**8.00%**	**1,794,647**	**0**	**N/A**	**627,328**	**35%**	**100%**
[redacted]	HCPHES/RWGA Section	1,183,084	119,600	0		0	1,302,684	5.81%	1,302,684	0	N/A	$462,731	36%	100%
[redacted]	RWPC Support*	491,963			0	0	491,963	2.19%	491,963	0	N/A	164,598	33%	100%

Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2019 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	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
[redacted]	**Quality Management**	**495,000**	**-119,600**	**0**	**0**	**0**	**375,400**	**1.67%**	**375,400**	**0**	**N/A**	**$84,702**	**23%**	**100%**
		21,398,944	**666,000**	**375,222**	**0**	**0**	**22,440,166**	**98.13%**	**22,440,335**	**-169**	[redacted]	**20,104,235**	**90%**	**100%**
								Unallocated	Unobligated					[redacted]
	Part A Grant Award:	**22,439,871**	***Carry Over:***	**465**		***Total Part A:***	**22,440,336**	**170**	**-169**					

	[redacted]	Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent
	Core (must not be less than 75% of total service dollars)	**16,702,984**	**666,000**	**275,222**	**25,000**	**0**	**17,669,206**	**87.17%**	**15,829,221**	**81.63%**
	Non-Core (may not exceed 25% of total service dollars)	**2,525,913**	**0**	**100,000**	**-25,000**	**0**	**2,600,913**	**12.83%**	**3,562,984**	**18.37%**
	Total Service Dollars (does not include Admin and QM)	**19,228,897**	**666,000**	**375,222**	**0**	**0**	**20,270,119**	[redacted]	**19,392,204**	[redacted]
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,675,047**	**119,600**	**0**	**0**	**0**	**1,794,647**	**8.00%**		
	Total QM (must be ≤ 5% of total Part A + MAI)	**495,000**	**-119,600**	**0**	**0**	**0**	**375,400**	**1.67%**		

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	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**	**1,846,845**	**40,438**	**18,861**	**0**	**0**	**1,906,144**	**85.62%**	**1,906,144**	**0**	[redacted]	**1,857,625**	**97%**	**100%**
1.b (MAI)	Primary Care - CBO Targeted to African American	934,693	20,219	9,430	0	0	964,342	43.32%	964,342	0	3/1/2019	$1,093,950	113%	100%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	912,152	20,219	9,431	0	0	941,802	42.30%	941,802	0	3/1/2019	$763,675	81%	100%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**0**	**320,100**	**14.38%**	**320,100**	**0**	[redacted]	**$210,675**	**66%**	100%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	7.19%	160,050	0	3/1/2019	$142,705	89%	100%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	7.19%	160,050	0	3/1/2019	$67,970	42%	100%
[redacted]	**Total MAI Service Funds**	**2,166,945**	**40,438**	**18,861**	**0**	**0**	**2,226,244**	**100.00%**	**2,226,244**	**0**	[redacted]	**2,068,300**	**93%**	**100%**
[redacted]	Grant Administration	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
[redacted]	Quality Management	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
[redacted]	**Total MAI Non-service Funds**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	[redacted]	**0**	**0%**	**0%**
[redacted]	**Total MAI Funds**	**2,166,945**	**40,438**	**18,861**	**0**	**0**	**2,226,244**	**100.00%**	**2,226,244**	**0**	[redacted]	**2,068,300**	**93%**	**100%**
	MAI Grant Award	**2,226,244**	***Carry Over:***	**0**		***Total MAI:***	**2,226,244**							[redacted]
	Combined Part A and MAI Orginial Allocation Total	**23,565,889**												

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 four (4) HRSA service categories (Pcare, LPAP, MCM, Non Med CM). Expenditures must be evaluated both by individual service category and by combined service categories.
(a.1)	Single local service definition is three (3) HRSA service categories (does not include LPAP). Expenditures must be evaluated both by individual service category and by combined service categories.
(b)	Adjustments to reflect actual award based on Increase or Decrease funding scenario.
(c)	Funded under Part B and/or SS
(d)	Not used at this time
(e)	10% rule reallocations

Prepared by: Ryan White Grant Administration

FY 2019 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR: 3rd Quarter (3/1-11/30)

Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans Gender	AA (not Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	[redacted]	**73%**	**26%**	**1%**	**46%**	**14%**	**2%**	**37%**	**0%**	**1%**	**5%**	**26%**	**27%**	**13%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	[redacted]	68%	31%	1%	50%	9%	2%	39%	0%	0%	2%	16%	26%	16%	36%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	[redacted]	66%	31%	3%	99%	0%	1%	0%	0%	1%	6%	39%	27%	11%	17%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	[redacted]	83%	15%	2%	0%	0%	0%	100%	0%	1%	7%	30%	31%	12%	17%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	[redacted]	88%	11%	1%	0%	87%	13%	0%	0%	0%	4%	30%	24%	13%	28%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	[redacted]	70%	29%	1%	45%	24%	2%	29%	0%	0%	7%	33%	26%	12%	21%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	[redacted]	0%	100%	0%	60%	8%	2%	31%	0%	0%	1%	10%	30%	18%	34%	5%
1.g	Primary Care - Pediatric (a)	7	[redacted]	100%	0%	0%	38%	13%	0%	50%	13%	50%	38%	0%	0%	0%	0%	0%
1.h	Vision	1,600	[redacted]	74%	25%	1%	47%	14%	3%	36%	0%	0%	4%	22%	24%	14%	32%	4%
2	**Medical Case Management (f)**	**3,075**	[redacted]															
2.a	Clinical Case Management	600	[redacted]	77%	21%	2%	52%	14%	2%	32%	0%	0%	3%	29%	26%	9%	28%	4%
2.b	Med CM - Targeted to Public Clinic (a)	280	[redacted]	92%	7%	1%	63%	11%	2%	24%	0%	0%	2%	30%	22%	11%	32%	3%
2.c	Med CM - Targeted to AA (a)	550	[redacted]	65%	32%	3%	99%	0%	1%	0%	0%	0%	6%	35%	26%	12%	18%	2%
2.d	Med CM - Targeted to H/L(a)	550	[redacted]	80%	16%	4%	0%	0%	0%	100%	0%	1%	7%	29%	34%	10%	18%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	[redacted]	85%	14%	1%	0%	87%	13%	0%	0%	0%	2%	23%	21%	15%	34%	4%
2.f	Med CM - Targeted to Rural (a)	150	[redacted]	67%	32%	1%	48%	27%	3%	22%	0%	0%	6%	23%	24%	13%	32%	4%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	[redacted]	0%	100%	0%	75%	7%	2%	16%	0%	0%	0%	11%	29%	15%	39%	5%
2.h	Med CM - Targeted to Pedi (a)	125	[redacted]	58%	42%	0%	68%	8%	1%	22%	60%	31%	10%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	[redacted]	96%	4%	0%	69%	22%	1%	8%	0%	0%	0%	1%	6%	3%	61%	31%
2.j	Med CM - Targeted to Youth	120	[redacted]	89%	11%	0%	44%	11%	0%	44%	0%	11%	89%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	[redacted]	**74%**	**24%**	**3%**	**47%**	**15%**	**2%**	**36%**	**0%**	**0%**	**5%**	**29%**	**28%**	**14%**	**23%**	**1%**
4	**Oral Health**	**200**	[redacted]	**65%**	**33%**	**1%**	**44%**	**32%**	**1%**	**22%**	**0%**	**0%**	**5%**	**21%**	**27%**	**11%**	**32%**	**4%**
4.a	Oral Health - Untargeted (d)	NA																
4.b	Oral Health - Rural Target	200	[redacted]	65%	33%	1%	44%	32%	1%	22%	0%	0%	5%	21%	27%	11%	32%	4%
5	**Mental Health Services (d)**	**NA**																
6	**Health Insurance**	**1,700**	[redacted]	**80%**	**19%**	**1%**	**46%**	**25%**	**3%**	**26%**	**0%**	**0%**	**2%**	**16%**	**19%**	**13%**	**40%**	**9%**
7	**Home and Community Based Services (d)**	**NA**																
8	**Substance Abuse Treatment - Outpatient**	**40**	[redacted]	**95%**	**5%**	**0%**	**21%**	**42%**	**5%**	**32%**	**0%**	**0%**	**5%**	**32%**	**21%**	**26%**	**16%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**																
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	[redacted]	**78%**	**22%**	**0%**	**41%**	**22%**	**3%**	**34%**	**0%**	**0%**	**1%**	**10%**	**17%**	**15%**	**46%**	**10%**
11	**Hospice Services (d)**	**NA**																
12	**Outreach**	**700**	[redacted]	**77%**	**21%**	**1%**	**58%**	**13%**	**1%**	**29%**	**0%**	**1%**	**9%**	**32%**	**23%**	**10%**	**24%**	**2%**
13	**Non-Medical Case Management**	**7,045**	[redacted]															
13.a	Service Linkage Targeted to Youth	320	[redacted]	78%	20%	2%	55%	4%	4%	37%	0%	17%	83%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	[redacted]	74%	25%	1%	53%	11%	4%	32%	0%	0%	0%	45%	29%	8%	14%	4%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	[redacted]	66%	33%	1%	61%	9%	1%	29%	0%	0%	0%	16%	24%	14%	40%	6%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	[redacted]	73%	24%	2%	53%	14%	2%	31%	1%	1%	7%	29%	25%	11%	24%	3%
14	**Transportation**	**2,850**	[redacted]															
14.a	Transportation Services - Urban	170	[redacted]	65%	33%	2%	61%	10%	3%	26%	0%	0%	5%	30%	26%	11%	25%	3%
14.b	Transportation Services - Rural	130	[redacted]	70%	29%	1%	33%	39%	3%	25%	0%	0%	3%	20%	27%	7%	40%	3%
14.c	Transportation vouchering	2,550	[redacted]															
15	**Linguistic Services (d)**	**NA**																
16	**Emergency Financial Assistance (e)**	**NA**	[redacted]	**74%**	**24%**	**2%**	**51%**	**12%**	**2%**	**35%**	**0%**	**1%**	**5%**	**27%**	**29%**	**12%**	**25%**	**1%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**																
Net unduplicated clients served - all categories*		**12,941**	[redacted]	**73%**	**25%**	**1%**	**52%**	**15%**	**2%**	**31%**	**0%**	**1%**	**4%**	**23%**	**24%**	**12%**	**30%**	**5%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 18 App) (b)		**NA**	**28,225**	**60%**	**21%**		**39%**	**18%**	**3%**	**20%**	**0%**	**5%**		**15%**	**22%**	**25%**	**15%**	

Available Data As Of: 3/2/2020

Prepared by: Ryan White Grant Administration

FY 2019 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 3rd Quarter (03/01-11/30)																		
Priority	Service Category - MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI 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	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	[redacted]	71%	26%	3%	100%	0%	0%	0%	0%	1%	7%	38%	26%	11%	17%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	[redacted]	83%	14%	2%	0%	0%	0%	100%	0%	0%	7%	30%	32%	13%	17%	1%
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	[redacted]	74%	23%	4%	46%	16%	3%	35%	0%	2%	7%	35%	31%	9%	15%	2%
2.d	Med CM - Targeted to H/L(a)	960	[redacted]	81%	14%	5%	48%	17%	2%	33%	0%	2%	5%	31%	33%	5%	24%	1%

RW Part A New Client Service Utilization Report - 3rd Quarter (03/01-11/30) Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/18 - 2/28/19)																		
Priority	Service Category	Goal	Unduplicated New 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	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	[redacted]	**76%**	**21%**	**2%**	**51%**	**13%**	**2%**	**34%**	**0%**	**2%**	**10%**	**35%**	**27%**	**10%**	**1%**	**16%**
2	**LPAP**	**1,200**	[redacted]	**74%**	**23%**	**4%**	**46%**	**16%**	**3%**	**35%**	**0%**	**2%**	**7%**	**35%**	**31%**	**9%**	**2%**	**15%**
3.a	Clinical Case Management	400	[redacted]	81%	14%	5%	48%	17%	2%	33%	0%	2%	5%	31%	33%	5%	1%	24%
3.b-3.h	Medical Case Management	1,600	[redacted]	74%	23%	3%	58%	13%	2%	28%	1%	2%	8%	34%	26%	9%	1%	18%
3.i	Medical Case Manangement - Targeted to Veterans	60	[redacted]	100%	0%	0%	59%	38%	3%	0%	0%	0%	0%	3%	12%	0%	38%	47%
4	**Oral Health**	**40**	[redacted]	**71%**	**23%**	**6%**	**49%**	**37%**	**0%**	**14%**	**0%**	**0%**	**11%**	**34%**	**11%**	**11%**	**6%**	**26%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	[redacted]	**73%**	**25%**	**2%**	**56%**	**14%**	**2%**	**29%**	**1%**	**2%**	**8%**	**28%**	**25%**	**10%**	**23%**	**4%**
12.b	**Service Linkage at Testing Sites**	**260**	[redacted]	**80%**	**18%**	**2%**	**49%**	**10%**	**4%**	**38%**	**0%**	**2%**	**15%**	**40%**	**25%**	**6%**	**10%**	**3%**

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

Available Data As Of: 3/2/2020

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1920 Ryan White Part B

Procurement Report

April 1, 2019 - March 31, 2020

Reflects spending through March 2020 Final

Spending Target: 100.0

Revised 5/21/20

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Care	$2,186,905	65%	$31,973	$2,218,878	-$184,119	$2,034,759	4/1/2019	$1,913,401	94%
5	Health Insurance Premiums and Cost Sharing	$1,040,351	31%	$0	$1,040,351	$24,474	$1,064,825	4/1/2019	$1,064,825	100%
8	Home and Community Based Health Services	$113,315	3%	$0	$113,315	$25,645	$138,960	4/1/2019	$138,960	100%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	-$31,973	$0					
	Total Houston HSDA	3,340,571	100%	0	3,372,544	-$134,000	$3,238,544		3,117,186	96%

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

* Result of Increased Scenario for RWB award

** TRG reallocated funds in final quarter to meet its required spending threshold of 95% and to avoid returning funds to DSHS. Thus, HCBHS was increased by $ 25,645, HIP was increased by $ 24,474 and $134,000 was reallocated to another HSDA

2019-2020 Ryan White Part B Service Utilization Report
4/1/2019- 03/31/2020 Houston HSDA (4816)
4th Quarter

Revised 5/1/2020

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums	1,600	1,362	81.00%	18.35%	0.07%	0.58%	41.48%	26.28%	29.31%	2.93%	0.00%	0.14%	1.02%	15.63%	17.10%	30.02%	28.04%	8.05%
Home and Communiy Based Health Services	38	24	75.00%	25.00%	0.00%	0.00%	66.66%	16.67%	16.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	45.83%	41.66%	12.51%
Oral Health Care	1505	3,513	71.15%	27.55%	0.02%	1.28%	52.09%	13.66%	32.25%	2.00%	0.00%	0.22%	2.41%	17.87%	22.43%	25.96%	23.54%	7.57%
Unduplicated Clients Served By State Services Funds:	NA	1,839	77.36%	21.66%	0.05%	0.93%	53.41%	18.87%	26.08%	1.64%	0.00%	0.12%	1.02%	11.17%	13.18%	33.94%	31.08%	9.49%

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1920 DSHS State Services

Procurement Report

September 1, 2019- August 31, 2020

Chart reflects spending through March 2020

Spending Target: 58.33

Revised 5/21/2020

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	Health Insurance Premiums and Cost Sharing (1)	$864,506	43%	$0	$864,506	$0	$864,506	9/1/2019	$0	0%
6	Mental Health Services (2)	$300,000	15%	$0	$300,000	$0	$300,000	9/1/2019	$88,408	29%
7	EIS - Incarcerated	$175,000	9%	$0	$175,000	$0	$175,000	9/1/2019	$95,747	55%
11	Hospice	$259,832	13%	$0	$259,832	$0	$259,832	9/1/2019	$132,880	51%
	Non Medical Case Management (3)	$350,000	17%	$0	$350,000	$0	$350,000	9/1/2019	$128,013	37%
15	Linguistic Services (4)	$68,000	3%	$0	$68,000	$0	$68,000	9/1/2019	$28,050	41%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	-$142,285						
	Total Houston HSDA	2,017,338	100%	-$142,285	$2,017,338	$0	$1,667,338		473,098	28%

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) Mental Health reporting services utilization is down and additional back billing has not been submitted.

(3) N-Medical Case Management a new agency is behind 2 months of reporting spending.

(4) Linguistic is behind with 1 month of reporting spending.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2019-3/31/20

Revised: 4/29/2020

Request by Type	Assisted			NOT Assisted		
	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	1180	$102,206.12	578			*0*
Medical Deductible	139	$20,904.36	111			*0*
Medical Premium	4044	$1,481,440.99	757			*0*
Pharmacy Co-Payment	11210	$395,329.57	1225			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	17	$1,614.02	9	*NA*	*NA*	*NA*
Totals:	16591	$1,998,767.02	2681	0	$0.00	

Comments: This report represents services provided under all grants.

DRAFT

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax
www.rwpchouston.org

FY 2021 How to Best Meet the Need Quality Improvement Committee Service Category Recommendations Summary (as of 05/28/20)

Those services for which no change is recommended include:

Case Management (Non-Medical Service Linkage)
Early Intervention Services (targeting the Incarcerated)
Home and Community Based Health Services (Adult Day Treatment)
Hospice Services
Linguistic Services
Oral Health (Untargeted and Targeting the Northern Rural Area)
Referral for Health Care and Support Services
Transportation
Vision Care

Services with recommended changes include the following:

Ambulatory Outpatient Medical Care (includes Medical Case Management, Local Pharmacy Assistance, Emergency Financial Assistance - Pharmacy Assistance, Outreach Services - Primary Care Re-Engagement, and Service Linkage)

- Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same at PriCare=300%, MCM=none, LPAP=400%+500%, EFA=500%, Outreach=none SLW=none.

Case Management (Clinical)

- Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same at none.

Case Management (Non-Medical Targeting Substance Use Disorders)

- Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same at none.

Emergency Financial Assistance

- Accept the service category definition for Emergency Financial Assistance-Other which will provide a rapid response to personal emergencies, and set the financial eligibility at 400%. The committee recommends that the subcategory begin immediately using CARES Act (COVID-19) funds. After March 1, 2021, use Ryan White or State Services funding. SEE NEXT PAGE.

Health Insurance Premium and Cost Sharing Assistance

- Add text to the service definition that states clients should receive notification that payments have been made to and received by their insurance provider, update the justification chart, and

keep the financial eligibility the same at 0 - 400%, ACA plans must have a subsidy.

Housing

- SEE BELOW. Refer the discussion on Housing to a workgroup for further research.

Medical Nutritional Therapy/Supplements

- Accept the service definition as presented, update the justification chart, and increase the financial eligibility to 400%.

Mental Health Services

- Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same at 400%.

Substance Abuse Treatment

- Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same at 300%.

On 05/27/20 the Housing Workgroup met and made the following recommendation which may or may not be approved by the Quality Improvement Committee on 06/02/20.

Emergency Financial Assistance

- Add housing to the FY 2021 Emergency Financial Assistance – Other service definition and limit it to people who are displaced from their home due to a temporary, acute housing need. Also, the Office of Support is to educate people living with HIV and appropriate staff to Houston EMA/HSDA housing resources. The financial eligibility is 400%, per the above motion.

DRAFT - 05/28/20

Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Other** (Revised April 2020)	
HRSA Service Category Title:	**Emergency Financial Assistance**
Local Service Category Title:	**Emergency Financial Assistance - Other**
Service Category Code **(RWGA use only):**	
Amount Available **(RWGA use only):**	
Budget Type **(RWGA use only):**	**Hybrid**
Budget Requirements or Restrictions:	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. Maximum allowable unit cost for provision of food vouchers or and/or utility assistance to an eligible client = $xx.00/unit
HRSA Service Category Definition **(do <u>not</u> change or alter):**	**Emergency Financial Assistance** - Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	**Emergency Financial Assistance** is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used. Emergency essential living needs include food, telephone, and utilities (i.e. electricity, water, gas and all required fees) for eligible PLWH.
Target Population (age, gender, geographic, race, ethnicity, etc.):	PLWH living within the Houston Eligible Metropolitan Area (EMA).

housing, limited to people who are displaced from their home due to acute housing needs,

Services to be Provided:	**Emergency Financial Assistance** provides funding through: • Short-term payments to agencies • Establishment of voucher programs Service to be provided include: • Food Vouchers • Utilities (gas, water, basic telephone service and electricity) The agency must adhere to the following guidelines in providing these services: • Assistance must be in the form of vouchers made payable to vendors, merchants, etc. No payments may be made directly to individual clients or family members. • Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. • Allowable support services with an $800/year/client cap.
Service Unit Definition(s): **(HIV Services use only)**	A unit of service is defined as provision of food vouchers or and/or utility assistance to an eligible client.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Agency must be dually awarded as HOWPA sub-recipient work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer of last resort, and for limited amounts, limited use, and limited periods of time. Additionally, agency must document ability to refer clients for food, transportation, and other needs from other service providers when client need is justified.
Staff Requirements:	None.
Special Requirements:	Agency must: Comply with the Houston EMA/HSDA Standards of Care and Emergency Financial Assistance service category program policies.

Houston EMA/HSDA Ryan White Part A Service Definition **COVID-19 Emergency Financial Assistance – Other** (Revised April 2020)	
HRSA Service Category Title:	**Emergency Financial Assistance**
Local Service Category Title:	**COVID-19 Emergency Financial Assistance - Other**
Service Category Code **(RWGA use only):**	
Amount Available **(RWGA use only):**	
Budget Type **(RWGA use only):**	**Hybrid**
Budget Requirements or Restrictions:	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. Maximum allowable unit cost for provision of allowable COVID-19 EFA service to an eligible client = $xx.00/unit
HRSA Service Category Definition **(do <u>not</u> change or alter):**	**Emergency Financial Assistance** - Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	**COVID-19 Emergency Financial Assistance** is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used. Emergency essential living needs include Personal Protective Equipment (PPE), cleaning supplies, COVID-19 self-isolation 14 day short term housing, food, telephone, and utilities (i.e. electricity, water, gas and all required fees) for eligible PLWH.
Target Population (age,	PLWH living within the Houston Eligible Metropolitan Area

gender, geographic, race, ethnicity, etc.):	(EMA).
Services to be Provided:	**Emergency Financial Assistance** provides funding through: • Short-term payments to agencies • Establishment of voucher programs • Disbursement of allowable COVID-19 related PPE and cleaning supplies Service to be provided include: • Food Vouchers • Utilities (gas, water, basic telephone service and electricity) • Personal Protective Equipment (PPE) • Cleaning supplies • COVID-19 self-isolation 14 day short term housing The agency must adhere to the following guidelines in providing these services: • Assistance must be in the form of vouchers made payable to vendors, merchants, etc. No payments may be made directly to individual clients or family members. • Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. • Allowable support services with an $800/year/client cap.
Service Unit Definition(s): **(RWGA use only)**	A unit of service is defined as provision of allowable COVID-19 EFA service to an eligible client.
Financial Eligibility:	No more than 400% of Federal Poverty Level
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Agency must be dually awarded as HOWPA sub-recipient work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer of last resort, and for limited amounts, limited use, and limited periods of time. Additionally, agency must document ability to refer clients for food, transportation, and other needs from other service providers when client need is justified.
Staff Requirements:	None.
Special Requirements:	Agency must: Comply with the Houston EMA/HSDA Standards of Care and Emergency Financial Assistance service category program policies.

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FY 2021 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage, Outreach, Emergency Financial Assistance - Pharmacy Assistance and Local Pharmacy Assistance Program (LPAP) Services**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	**Comprehensive Primary Medical Care – Community Based:** i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older **Outreach:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Approved Financial Eligibility for Houston EMA/HSDA*

Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance. **Outreach**

	Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an

	eligible PLWHA performed by a qualified service linkage worker. • Outreach: 15 Minutes = 1 Unit • Emergency Financial Assistance – Pharmacy Assistance: A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence

	to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. • **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health

	education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.

- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.
- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site.

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.

	• Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to

	mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability

	that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA – Pharmacy Assistance Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications.

	Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.

Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers within 30 days of start of grant year, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client

	services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers within 30 days of start of grant year, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract.

	For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication

	regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none
1. Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic **Outreach:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.

Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last

	resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance. **Outreach** Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the

	Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. • Outreach: 15 Minutes = 1 Unit • Emergency Financial Assistance – Pharmacy Assistance: A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part

	B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. • **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**

Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral).

	• On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Women's Services must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if

clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.
- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

Local Medication Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP

	dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of

	bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.

	LPAP and EFA – Pharmacy Assistance Services: Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources.

	Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a

	minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.

Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and

	include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible

	transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none
1. Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Emergency Financial Assistance – Pharmacy Assistance 5. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA.

	Local Pharmacy Assistance Program (LPAP): Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary)

	• Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. • Emergency Financial Assistance – Pharmacy Assistance: A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
HRSA Service Category Definition:	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or

RWGA Only	nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case

	management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection;

	• Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.

- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.

	• Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and

	educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related

	medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA – Pharmacy Assistance Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA.

	Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers,

	Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care

	for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client

	is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows:

	Expiration of Current Bus Pass: In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none
1. Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	*See Current Fiscal Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible

	PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or**

	exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral).

- Specialty Clinic Referrals (either on-site or via referral).
- On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral.
- On site Nutritional Counseling by a Licensed Dietitian.

Services for females of child bearing age must also provide:

- Well woman care, including but not limited to: PAP, pelvic exam, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications.
- Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.
- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.
- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.

	• Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the

	situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas,

	who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/17, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/17, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management and Service Linkage (non-medical Case Management) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the

	Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS

	business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: PriCare=300%, MCM=none, SLW=none
1. Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Clinical Case Management	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition: **RWGA Only**	***Medical Case Management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies.
Target Population (age,	Services will be available to eligible HIV-infected clients residing in

gender, geographic, race, ethnicity, etc.):	the Houston EMA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling (i.e. professional counseling), substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. *Clinical Case Management* is intended to serve eligible clients, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	Provision of Clinical Case Management activities performed by the Clinical Case Manager. *Clinical Case Management* is a working agreement between a client and a Clinical Case Manager for a defined period of time based on the client's assessed needs. *Clinical Case Management* services include performing a comprehensive assessment and developing a clinical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance in order to maximize benefit of mental health and/or substance abuse treatment services. The *Clinical Case Manager* serves as an advocate for the client and as a liaison with mental health, substance abuse and medical treatment providers on behalf of the client. The Clinical Case Manager ensures linkage to mental health, substance abuse, primary medical care and other client services as indicated by the clinical service plan. The Clinical Case Manager will perform *Mental Health* and *Substance Abuse/Use Assessments* in accordance with RWGA Quality Management guidelines. Service plan must reflect an ongoing discussion of mental health treatment and/or substance abuse treatment, primary medical care and medication adherence, per client need. *Clinical Case Management is* both office and community-based. Clinical

	Case Managers will interface with the primary medical care delivery system as necessary to ensure services are integrated with, and complimentary to, a client's medical treatment plan.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	*Clinical Case Management* services will comply with the HCPHS/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system *Clinical Case Management Services* must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services (categories b., c. and d. as listed under *Amount Available* above) or substance abuse treatment services to PLWH/A (category a. under *Amount Available* above) in the Houston EMA. Specifically, an applicant for this service category must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services (as applicable to the specific CCM category being applied for) in the previous calendar or grant year to individuals with an HIV diagnosis. Acceptable documentation for such treatment activities includes standardized reporting documentation from the County's *CPCDMS* or Texas Department of State Health Services' *ARIES* data systems, Ryan White Services Report (RSR), SAMSHA or TDSHS/SAS program reports or other verifiable published data. Data submitted to meet this requirement is subject to audit by HCPHS/RWGA prior to an award being recommended. **Agency-generated non-verifiable data is not acceptable.** In addition, applicant agency must demonstrate it has the capability to continue providing mental health treatment and/or substance abuse treatment services for the duration of the contract term and any subsequent one-year contract renewals. Acceptable documentation of such continuing capability includes current funding from Ryan White (all Parts), TDSHS HIV-related funding (Ryan White, State Services, State-funded Substance Abuse Services), SAMSHA and other ongoing federal, state and/or public or private foundation HIV-related funding for mental health treatment and/or substance abuse treatment services. Proof of such funding must be documented in the application and is subject to independent verification by HCPHS/RWGA prior to an award being recommended. Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services as applicable may result in the termination of Clinical Case Management Services

	awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on applicant agency maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term. **Applicant agency must be Medicaid and Medicare Certified.**
Staff Requirements:	Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules. *Must comply with applicable HCPHS/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:* <u>Minimum Qualifications:</u> **Clinical Case Managers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences and have a current and in good standing State of Texas license (LBSW, LSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A or higher level of licensure). The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic PLWHA must demonstrate both written and verbal fluency in Spanish. <u>Supervision:</u> The **Clinical Case Manager** (CCM) must function with the clinical infrastructure of the applicant agency and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If applicant agency also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is <u>not</u> client specific is considered **indirect time** and is not billable.
Special Requirements: **RWGA Only**	Contractor must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent (FTE) CCM positions among other contracts or to employ part-time staff. **Contractor must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than 3/30/17. Contractor must inform RWGA in writing of any**

	changes in personnel assigned to contract within seven (7) business days of change. Contractor must comply with CPCDMS data system business rules and procedures. Contractor must perform CPCDMS new client registrations and registration updates for clients needing ongoing case management services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: None
1. Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Service Linkage at Testing Sites**	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA** **Not-In-Care PLWHA** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Local Service Category Definition:	**A.** ***Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or ***Not-In-Care*** PLWHA who know their status but are not currently enrolled

	in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Providing Ryan White Program appropriate outreach and service linkage activities to newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**A. Service Linkage:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. **Service Linkage** is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Services will be available to eligible HIV-infected Youth (ages 13 – 24) residing

	in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served without regard to age (i.e. limited to those who are between 13- 24 years of age), gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income Youth living with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target Youth who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. ***Youth Targeted Service Linkage, Care and Prevention*** is intended to serve eligible youth in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	**Goal (A): Service Linkage:** The expectation is that a single Service Linkage Worker Full Time Equivalent (FTE) targeting Not-In-Care and/or newly-diagnosed PLWHA can serve approximately 80 newly-diagnosed or not-in-care PLWH/A per year. The purpose of **Service Linkage** is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. **Service Linkage** is a working agreement between a client and a Service Linkage Worker (SLW) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of **Service Linkage** is to assist clients who do not require the intensity of *Clinical or Medical Case Management*, as determined by RWGA Quality Management guidelines. **Service Linkage** is both office- and field-based and **may include the issuance of bus pass vouchers and gas cards per published guidelines.** Service Linkage targeted to Not-In-Care and/or Newly-Diagnosed PLWHA extends the capability of existing programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWHA by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services.

	In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 90 days of initiation of services as documented in both ECLIPS and CPCDMS data systems. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing service linkage services from provider or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client. **GOAL (B):** This effort will continue a program of ***Service Linkage, Care and Prevention to Engage HIV Seropositive Youth*** targeting youth (ages 13-24) with a focus on Youth of color. This service is designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link HIV-infected Youth with primary care services, and (3) prevent transmission of HIV infection from targeted clients.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	**Service Linkage** services will comply with the HCPHS/RWGA published **Service Linkage** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. Agency must comply with all applicable City of Houston DHHS *ECLIPS* and RWGA/HCPHS *CPCDMS* business rules and policies & procedures. **Service Linkage** targeted to Not-In-Care and/or newly diagnosed PLWHA must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV/AIDS primary care providers.

Staff Requirements:	Service Linkage Workers must spend at least 42% (867 hours per FTE) of their time providing direct client services. Direct service linkage and case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the CPCDMS according to system business rules. *Must comply with applicable HCPHS/RWGA published Ryan White Part A/B Standards of Care:* Minimum Qualifications: **Service Linkage Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Supervision: The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.
Special Requirements: **RWGA Only**	Contractor must be have the capability to provide Public Health Follow-Up by qualified Disease Intervention Specialists (DIS) to locate, identify, inform and refer newly-diagnosed and not-in-care PLWHA to outpatient primary medical care services. Contractor must perform CPCDMS new client registrations and, for those newly-diagnosed or out-of-care clients referred to non-Ryan White primary care providers, registration updates per RWGA business rules for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. This service category does not routinely distribute Bus Passes. However, if so directed by RWGA, Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**		Date: **04/21/2020**
Recommendations:	Financial Eligibility: None	
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.		
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Local Service Category:	**Care Coordination (Non-Medical Case Management) Targeting Substance Use Disorder**
Amount Available:	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.
DSHS Service Category Definition:	**Care Coordination** is a continuum of services that allow people living with HIV to be served in a holistic method. Services that are a part of the Care Coordination Continuum include case management, (both medical and non-medical, outreach services, referral for health care, and health education/risk reduction. **Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program. Limitation: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical

	Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: - Transgender, - Men who have sex with men (MSM), - Women or - Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services.

	Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a duplication of service but rather a set of agreed upon coordinated activities that clearly delineate the unique and separate roles of N-MCMs and medical case managers who work jointly and collaboratively with the PLWH's knowledge and consent to partialize and prioritize goals in order to effectively achieve those goals. N-MCMs should provide activities that enhance the motivation of PLWHs on N-MCM's caseload to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors. N-MCMs shall use motivational interviewing techniques and the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change). N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations. N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction. Those PLWHs who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing Non-Medical Case Management services from provider.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct services or coordination of care on behalf of PLWH.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHs dealing with challenges of substance use/abuse and dependence. Resident of the Houston HSDA.
Agency Requirements **(TRG Only)**:	These services will comply with the TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system as well as DSHS Universal Standards and Non-

	Medical Case Management Standards of Care. **Non-Medical Case Management targeted SUD** must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Subrecipients must document established linkages with agencies that serve PLWH or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	Minimum Qualifications: **Non-Medical Case Management Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Supervision: The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling.

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Step in Process: **Steering Committee**		Date: **06/04/2020**
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
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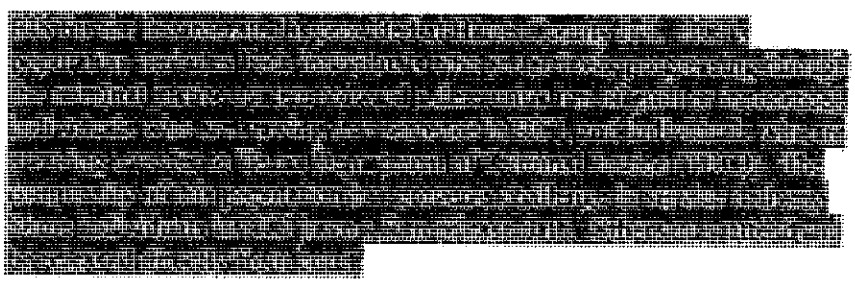
Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: None
1. Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Local Service Category:	**Early Intervention Services – Incarcerated**
Amount Available:	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care These services must focus on expanding key points of entry and documented tracking of referrals. Counseling, testing, and referral activities are designed to bring people living with HIV into Outpatient Ambulatory Medical Care. The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. [redacted]
Local Service Category Definition:	This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client's health literacy, [redacted], care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV (PLWHs) incarcerated in The Harris County Jail.
Services to be Provided:	Services include but are not limited to CPCDMS registration/update, assessment, provision of client education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources.  [redacted]

	service provision haven been designated. They are: • **Tier 0:** The individuals in this tier do **not** stay in HCJ long enough to receive a clinical appointment while incarcerated. The use of zero for this tier's designation reinforces the understanding that the interaction with funded staff will be minimal. The length of stay in this tier is traditionally less than 14 days. • **Tier 1:** The individuals in this tier stay in HCJ long enough to receive a clinical appointment while incarcerated. This clinical appointment triggers the ability of staff to conduct multiple interactions to assure that certain benchmarks of service provision should be met. The length of stay in this tier is traditionally 15-30 days. • **Tier 2:** The individuals in this tier remain in HCJ long enough to get additional interactions and potentially multiple clinical appointments. The length of stay in this tier is traditionally 30 or more days. Service provision builds on the activities of the previous tier if the individual remains in HCJ. Each tier helps the staff to focus interactions to address the highest priority needs of the individual. Each interaction is conducted as if it is the only opportunity to conduct the intervention with the individual.
Service Unit Definition(s) **(TRG Only):**	One unit of service is defined as 15 minutes of direct client services or coordination of care on behalf of client.
Financial Eligibility:	Due to incarceration, no income or residency documentation is required.
Client Eligibility:	People living with HIV incarcerated in the Harris County Jail.
Agency Requirements **(TRG Only):**	As applicable. the agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services. Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who are identified by testing in HCJ. Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only):**	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Early Intervention Services Standards of Care** and **the Houston HSDA Early Intervention Services for the Incarcerated Standards of Care.** The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **Steering Committee**		Date: **06/04/2020**
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**		Date: **04/22/2020**
Recommendations:	Financial Eligibility: None	
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.		
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2019-20 Service Category Definition
Ryan White Part B and DSHS State Services

Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
Amount Available:	**To be determined**
Budget Requirements or Restrictions (**TRG Only**):	Contractor must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed. ADAP dispensing fees are not allowable under this service category.
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help people living with HIV continue medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans) within the Houston HSDA.
Services to be Provided:	Contractor may provide assistance with: • Insurance premiums, • And deductibles, co-insurance and/or co-payments.
Service Unit Definition (**TRG Only**):	A unit of service will consist of payment of health insurance premiums, co-payments, co-insurance, deductible, or a combination.
Financial Eligibility:	Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: Clients who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.
Client Eligibility:	People living with HIV in the Houston HSDA and have insurance or be eligible (within local financial eligibility guidelines) to purchase a Qualified Health Plan through the Marketplace.

Agency Requirements (**TRG Only**):	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency. • Conduct marketing in-services with Houston area HIV/AIDS service providers to inform them of this program and how the client referral and enrollment processes function. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilizes the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it (premiums take precedence). o **Priority Ranking of Requests (in descending order):** ▪ HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) ▪ Non-HIV medication co-pays and deductibles ▪ Co-payments for provider visits (eg. physician visit and/or lab copayments) ▪ Medicare Part D (Rx) premiums ▪ APTC Tax Liability ▪ Out of Network out-of-pocket expenses • Utilizes the RW Planning Council –approved consumer out-of-pocket methodology.
Special Requirements (**TRG Only**):	Must comply with the DSHS Health Insurance Assistance Standards of Care and the Houston HSDA Health Insurance Assistance Standards of Care ~~and pending the most current DSHS guidance, client must:~~ ~~• Purchase Silver Level Plan with formulary equivalency~~ ~~• Take advance premium credit~~ ~~• No assistance for Part C Network out-of-pocket expenses without prior approval of the Administrative Agent~~ ~~Must comply with DSHS Interim Guidance~~ –Must comply with updated guidance from DSHS. Must comply with the Eastern HASA Health Insurance Assistance Policy and Procedure ~~HIA-17015~~.

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Step in Process: **Steering Committee**		Date: **06/04/2020**
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 0-400%, ACA plans must have a subsidy
1. Add text to the service definition that states clients should receive notification that payments have been made to and received by their insurance provider, update the justification chart, and keep the financial eligibility the same.	
2.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Health Insurance Co-Payments and Co-Insurance Assistance	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type:	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition:	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.
Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.

Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	HIV-infected individuals residing in the Houston EMA meeting financial eligibility requirements and have insurance or be eligible to purchase a Qualified Health Plan through the Marketplace.
Agency Requirements:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Ensure that assistance provided to clients does not duplicate services already being provided through Ryan White Part B or State Services. The process for ensuring this requirement must be fully documented. • Have mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS upon submission of the client's tax return for those clients that receive financial assistance for eligible out of pocket costs associated with the purchase and use of Qualified Health Plans obtained through the Marketplace. • Conduct marketing with Houston area HIV/AIDS service providers to inform such entities of this program and how the client referral and enrollment processes function. Marketing efforts must be documented and are subject to review by RWGA. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied without notifying the Administrative Agency. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilize RWGA approved prioritization of cost sharing assistance, when limited funds warrant it. • Utilize consumer out-of-pocket methodology approved by RWGA.
Staff Requirements:	None
Special Requirements:	Agency must: • Comply with the Houston EMA/HSDA Standards of Care and Health Insurance Assistance service category program policies.

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Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 0-400%, ACA plans must have a subsidy
1. Add text to the service definition that states clients should receive notification that payments have been made to and received by their insurance provider, update the justification chart, and keep the financial eligibility the same.	
2.	
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Local Service Category:	**Home and Community-Based Health Services (Facility-Based)**
Amount Available:	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost
DSHS Service Category Definition:	Home and Community-Based Health Care Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following: • **Para–professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help clients remain in their homes. • **Professional care** is the provision of services in the home by licensed health care workers such as nurses. • **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high–tech therapies. physical therapy, social worker services. Home and Community-Based Health Care Providers work closely with the multidisciplinary care team that includes the client's case manager, primary care provider, and other appropriate health care professionals. Allowable services include: • Durable medical equipment • Home health aide and personal care services • Day treatment or other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services • Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities
Local Service Category Definition:	***Home and Community-based Health Services (facility-based)*** *is* defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are **NOT** included.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Eligible recipients for home and community-based health services are persons living with HIV residing within the Houston HIV Service Delivery Area (HSDA) who are at least 18 years of age.
Services to be Provided:	Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of clients through the provision of treatment and activities of daily living. Services must include: • **Skilled Nursing:** Services to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient

	care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. • **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. • **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. • **Education:** Services to include instructional workshops of HIV related topics and life skills. Services will be provided at least Monday through Friday for a minimum of 10 hours/day.
Service Unit Definition(s):	A unit of service is defined as one (1) visit/day of care for one (1) client for a minimum of four hours. Services consist of medical health care and social services at a licensed adult day.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	People living with HIV at least 18 years of age residing within the Houston HSDA.
Agency Requirements:	Must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider.
Staff Requirements:	• **Skilled Nursing Services** must be provided by a Licensed Vocational or Registered Nurse. • **Other Therapeutic Services** are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, and LMFTA). • **Nutritional Services** are provided by a Registered Dietician and food managers. • **Education Services** are provided by a health educator.
Special Requirements:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Home and Community-Based Health Services Standards of Care** and **Houston HSDA**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **Steering Committee**		Date: **06/04/2020**
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/22/2020**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Local Service Category:	**Hospice Services**
Amount Available:	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
DSHS Service Category Definition:	Provision of end-of-life care provided by licensed hospice care providers to clients in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and having a life expectancy of 6 months or less residing in the Houston HIV Service Delivery (HSDA).
Services to be Provided:	Services must include but are not limited to medical and nursing care,

	palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Services NOT allowed under this category: • HIV medications under hospice care unless paid for by the client. • Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents. • Funeral, burial, cremation, or related expenses. • Nutritional services, • Durable medical equipment and medical supplies. • Case management services. • Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding CANNOT pay for these services per legislation!
Service Unit Definition(s):	A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	Individuals with an AIDS diagnosis and certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course
Agency Requirements:	Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation or is certified as a Special Care Facility with Hospice designation. Provider must inform Administrative Agency regarding issue of long-term care facilities denying admission for people living with HIV based on inability to provide appropriate level of skilled nursing care. Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.

	Staff will refer Medicaid/Medicare eligible clients to a Hospice Provider for medical, support, and palliative care. Staff will document an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
Staff Requirements:	All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas.
Special Requirements:	These services must be: a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement; b) Provided by a medically directed interdisciplinary team; c) Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client. d) Residents seeking care for hospice at Agency must first seek care from other facilities and denial must be documented in the resident's chart. Must comply with the **Houston HSDA Hospice Standards of Care**. The agency must comply with **the DSHS Hospice Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **Steering Committee**		Date: **06/04/2020**
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/22/2020**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
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Local Service Category:	**Linguistics Services**
Amount Available:	**To be determined**
Unit Cost:	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to people living with HIV (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between client and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any client seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing impaired HIV+ persons. Services exclude Spanish Translation Services.
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible client.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	people living with HIV in the Houston HSDA
Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston HSDA **Linguistic Services Standards of Care**. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **HTBMTN Workgroup #3**	Date: **04/22/2020**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Medical Nutritional Therapy	
HRSA Service Category Title: **RWGA Only**	**Medical Nutritional Therapy**
Local Service Category Title:	**Medical Nutritional Therapy and Nutritional Supplements**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	***Supplements:*** An individual client may not exceed $1,000.00 in supplements annually without **prior** approval by RWGA. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks.
HRSA Service Category Definition: **RWGA Only**	***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit **and may include the provision of nutritional supplements.**
Local Service Category Definition:	***Supplements:*** Up to a 90-day supply at any given time, per client, of approved nutritional supplements that are listed on the Houston EMA/HSDA Nutritional Supplement Formulary. Nutritional counseling must be provided for each disbursement of nutritional supplements. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks. Services must be provided under written order from a state licensed medical provider (MD, DO or PA) with prescribing privileges and must be based on a written nutrition plan developed by a licensed registered dietician.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected persons living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA).
Services to be Provided:	***Supplements:*** The provision of nutritional supplements to eligible clients with a written referral from a licensed physician or PA that specifies frequency, duration and amount and includes a written nutritional plan prepared by a licensed, registered dietician. *Nutritional Supplement Disbursement Counseling* is a component of

	Medical Nutritional Therapy. Nutritional Supplement Disbursement Counseling is a component of the disbursement transaction and is defined as the provision of information by a licensed registered dietitian about therapeutic nutritional and/or supplemental foods that are beneficial to the wellness and increased health condition of clients provided in conjunction with the disbursement of supplements. Services may be provided either through educational or counseling sessions. Also included in this service are follow up sessions with clients' Primary Care provider regarding the effectiveness of the supplements. The number of sessions for each client shall be determined by a written assessment conducted by the Licensed Dietitian but may not exceed twelve (12) sessions per client per contract year. ***Medical Nutritional Therapy:*** Service must be provided under written order of a state licensed medical provider (MD, DO, PA) with prescribing privileges and must include a written plan developed by state licensed registered dietician. Client must receive a full range of medical nutritional therapy services including, but not limited to, diet history and recall; estimation of nutrition intake; assessment of weight change; calculation of nutritional requirements related to specific medication regimes and disease status, meal preparation and selection suggestions; calorie counts; evaluation of clinically appropriate laboratory results; assessment of medication-nutrient interactions; and bio-impedance assessment. If patient evaluation indicates the need for interventions such as nutritional supplements, appetite stimulants, or treatment of underlying pathogens, the dietician must share such findings with the patient's primary medical provider (MD, DO or PE) and provide recommendations. Clients needing additional nutritional resources will be referred to case management services as appropriate and/or local food banks. Provider must furnish information on this service category to at least the health care providers funded by Ryan White Parts A, B, C and D and TDSHS State Services.
Service Unit Definition(s): **RWGA Only**	***Supplements:*** One (1) unit of service = a single visit wherein an eligible client receives allowable nutritional supplements (up to a 90 day supply) and nutritional counseling by a licensed dietician as clinically indicated. A visit wherein the client receives counseling but no supplements is not a billable disbursement transaction. ***Medical Nutritional Therapy:*** An individual nutritional counseling session lasting a minimum of 45 minutes.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	***Nutritional Supplements:*** HIV-infected and documentation that the client is actively enrolled in primary medical care.

	Medical Nutritional Therapy: HIV-infected resident and documentation that the client is actively enrolled in primary medical care.
Agency Requirements:	None.
Staff Requirements:	The nutritional counseling services under this category must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years experience providing nutritional assessment and counseling to PLWHA.
Special Requirements: **RWGA Only**	Must comply with Houston EMA/HSDA Part A/B Standards of Care, HHS treatment guidelines and applicable HRSA/HAB HIV Clinical Performance Measures. Must comply with the Houston EMA/HSDA approved Medical Nutritional Therapy Formulary.

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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 400% (increased from 300%)
1. Accept the service definition as presented, update the justification chart, and increase the financial eligibility to 400%.	
2.	
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Local Service Category:	**Mental Health Services**
Amount Available:	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a family/couples, group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family/couple) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for family members or significant others of people living with HIV.
Local Service Category Definition:	**Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible person living with HIV. **Family/Couples Therapy/Counseling** is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible person living with HIV. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise people living with HIV, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and affected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Agencies are encouraged to have available to clients all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.

Service Unit Definition(s) **(TRG Only)**:	**Individual Crisis Intervention and/or Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **Family/Couples Crisis Intervention and/or Therapy:** A unit of service is defined as a family/couples counseling session lasting a minimum of 90 minutes. **Group Therapy:** A unit of service is defined as one (1) eligible client attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90 minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session. A minimum of three (3) clients must attend a group session in order for the group session to eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	For individual therapy session, person living with HIV or the affected significant other of a person living with HIV, resident of Houston HSDA. Person living with HIV must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, if the client applies for the other programs /providers, until the other programs/providers can take over services. Medicaid/Medicare, Third Party Payer and Private Pay status of clients receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, client must be either a person living with HIV or the significant other of person living with HIV. Affected significant other is eligible for services only related to the stress of caring for a person living with HIV.
Agency Requirements **(TRG Only)**:	Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions. Must provide 24-hour access to a licensed counselor for current clients with

	emotional emergencies. Clients eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential clients who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this grant). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of the provider's contract. Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.
Staff Requirements:	It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC PhD, Psychologist, or LMFT). At least two years' experience working with HIV disease or two years' work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years' experience in family therapy. Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. Mental health services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws. [redacted]

	When psychiatry is provided as a mental health service via telehealth then the provider must follow guidelines for telemedicine as noted in Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the client's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third-party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per client in any single 24-hour period. Agency should develop services that focus on the most current Special Populations identified in the *Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU), Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 400%
1. Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same.	
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Local Service Category:	**Oral Health Care**
Amount Available:	**To be determined**
Unit Cost:	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Costs
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years of age or older must be based on a comprehensive individual treatment plan. Prosthodontics services to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV residing in the Houston HIV Service Delivery Area (HSDA).

Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard oral health education and preventive procedures, including oral hygiene instruction, smoking/tobacco cessation (as indicated), diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns and bridges; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
	
	Limitations:
	• Cosmetic dentistry for cosmetic purposes only is prohibited.
	• Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year.
	  • In cases of emergency, the maximum amount may exceed the above cap
	  • In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap.
	• Dental providers must document *via approved waiver* the reason for exceeding the yearly maximum amount.

Service Unit Definition(s) **(TRG Only)**:	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication

	(including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines. Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year.
Client Eligibility:	Person living with HIV; Adult resident of Houston HSDA
Agency Requirements (**TRG Only**):	**To ensure that Ryan White is payer of last resort, Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible clients in the Houston EMA/HSDA.** Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible patients remains current throughout the contract term. Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Dental facility and appropriate dental staff must maintain Texas licensure/certification and follow all applicable OSHA requirements for patient management and laboratory protocol.
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements (**TRG Only**):	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Oral Health Care Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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20 Houston EMA Ryan White Part A/MAI Service Definition **Oral Health/Rural**	
HRSA Service Category Title: **RWGA Only**	**Oral Health**
Local Service Category Title:	**Oral Health – Rural (North)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not Applicable
HRSA Service Category Definition: **RWGA Only**	**Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV-infected individuals including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
Service Unit Definition(s): **RWGA Only**	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root

	canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected adults residing in the rural area of Houston EMA/HSDA meeting financial eligibility criteria.
Agency Requirements:	Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Service delivery site must be located in one of the northern counties of the EMA/HSDA area: Waller, Walker, Montgomery, Austin, Chambers or Liberty Counties
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements: **RWGA Only**	Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible clients in the Houston EMA/HSDA. Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible patients remains current throughout the contract term. Must comply with the joint Part A/B standards of care where applicable.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/04/2020**
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Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Service Category Definition - DSHS State Services-R
September 1, 2019 - August 31, 2020

Local Service Category:	**Referral for Health Care: ADAP Enrollment Worker**
Amount Available:	**To be determined**
Unit Cost	
Budget Requirements or Restrictions (**TRG Only**):	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Direct a client to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with the submission of complete, accurate ADAP applications. AEWs will submit annual re-certifications by the last day of the client's birth month and semi-annual Attestations six months later to ensure there is no the lapse in ADAP eligibility and loss of benefits. Other responsibilities will include: • Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible; • Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible; AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program.
Services to be Provided:	Services include but are not limited to completion of ADAP applications/six-month attestations/recertifications, gathering of supporting documentation for ADAP applications/six-month attestations/recertifications, submission of ADAP applications/six-month attestations/recertifications, and interactions with clients as part of the ADAP application process.
Service Unit Definition(s) (**TRG Only**):	One unit of service is defined as 15 minutes of direct client services or coordination of application process on behalf of client.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	People living with HIV in the Houston HDSA
Agency Requirements (**TRG Only**):	Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS.
Staff Requirements:	Not Applicable.
Special Requirements (**TRG Only**):	The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: None
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Substance Abuse Services - Outpatient**	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/ disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of

	Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse. Provider must provide a written plan no later than 3/30/17 documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA.
Staff Requirements:	Must meet all applicable State licensing requirements and Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 300%
1. Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Medical Transportation (Van Based)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report (CER).

	• A copy of the taxi company's statement (on company letterhead) must be included with the monthly CER. Supporting documentation of disbursement payments may be requested with the CER.
HRSA Service Category Definition: **RWGA Only**	**Medical transportation services** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
Local Service Category Definition:	a. Urban Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Harris County. Clients residing outside of Harris County are ineligible for Urban transportation services. Exceptions to this requirement require prior written approval from RWGA. b. Rural Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Houston EMA/HSDA counties other than Harris County. Clients residing in Harris County are ineligible for this transportation program. Exceptions to this requirement require prior written approval from RWGA. Essential transportation is defined as transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. The Contractor shall ensure that the transportation program provides taxi vouchers to eligible clients only in the following cases: • To access emergency shelter vouchers or to attend social security disability hearings; • Van service is unavailable due to breakdown or inclement weather; • Client's medical need requires immediate transport; • Scheduling Conflicts. **Contractor must provide clear and specific justification (reason) for the use of taxi vouchers and include the documentation in the client's file for each incident. RWGA must approve supporting documentation for taxi voucher reimbursements.** For clients living in the METRO service area, written certification from the client's principal medical provider (e.g. medical case manager or physician) is required to access van-based transportation, to be renewed every 180 days. **Medical Certifications should be maintained on-site by the provider in a single file (listed alphabetically by 11-digit code) and will be monitored at least annually during a Site Visit.** It is the

	Contractor's responsibility to determine whether a client resides within the METRO service area. Clients who live outside the METRO service area but within Harris County (e.g. Baytown) are not required to provide a written medical certification to access van-based transportation. All clients living in the Metro service area may receive a maximum of 4 non-certified round trips per year (including taxi vouchers). Non-certified trips will be reviewed during the annual Site Visit. Provider must maintain an up-to-date spreadsheet documenting such trips. The Contractor must implement the general transportation program in accordance with the Transportation Standards of Care that include entering all transportation services into the Centralized Patient Care Data Management System (CPCDMS) and providing eligible children with transportation services to Core Services appointments. Only actual mileage (documented per the selected Internet mapping program) transporting eligible clients from Origin to Destination will be reimbursed under this contract. The Contractor must make reasonable effort to ensure that routes are designed in the most efficient manner possible to minimize actual client time in vehicles.
Target Population (age, gender, geographic, race, ethnicity, etc.):	a. Urban Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Harris County. b. Rural Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Fort Bend, Waller, Walker, Montgomery, Austin, Colorado, Liberty, Chambers and Wharton Counties.
Services to be Provided:	To provide Medical Transportation services to access Ryan White Program defined **Core Services** for eligible individuals. Transportation will include round trips to single destinations and round trips to multiple destinations. Taxi vouchers will be provided to eligible clients only for identified emergency situations. Caregiver must be allowed to accompany the HIV-infected rider. **Eligibility for Transportation Services is determined by the client's County of residence as documented in the CPCDMS.**
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = one (1) mile driven with an eligible client as passenger. Client cancellations and/or no-shows are not reimbursable.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	a. Urban Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing inside Harris County will be eligible for services. b. Rural Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing in Houston EMA/HSDA Counties other than Harris County are eligible for Rural Transportation services. Documentation of the client's eligibility in accordance with approved

	Transportation Standards of Care must be obtained by the Contractor prior to providing services. The Contractor must ensure that eligible clients have a signed consent for transportation services, client rights and responsibilities prior to the commencement of services. Affected significant others may accompany an HIV-infected person as medically necessary (minor children may accompany their caregiver as necessary). Ryan White Part A/B eligible affected individuals may utilize the services under this contract for travel to Core Services when the aforementioned criteria are met and the use of the service is directly related to a person with HIV infection. An example of an eligible transportation encounter by an affected individual is transportation to a Professional Counseling appointment.
Agency Requirements	Proposer must be a Certified Medicaid Transportation Provider. Contractor must furnish such documentation to Harris County upon request from Ryan White Grant Administration prior to March 1st annually. Contractor must maintain such certification throughout the term of the contract. Failure to maintain certification as a Medicaid Transportation provider may result in termination of contract. Contractor must provide each client with a written explanation of contractor's scheduling procedures upon initiation of their first transportation service, and annually thereafter. Contractor must provide RWGA with a copy of their scheduling procedures by March 30, 2014, and thereafter within 5 business days of any revisions. **Contractor must also have the following equipment dedicated to the general transportation program:** • A separate phone line from their main number so that clients can access transportation services during the hours of 7:00 a.m. to 10:00 p.m. directly at no cost to the clients. **The telephone line must be managed by a live person between the hours of 8:00 a.m. – 5:00 p.m.** Telephone calls to an answering machine utilized after 5:00 p.m. must be returned by 9:00 a.m. the following business day. • A fax machine with a dedicated line. • All equipment identified in the Transportation Standards of Care necessary to transport children in vehicles. • Contractor must assure clients eligible for Medicaid transportation are billed to Medicaid. This is subject to audit by the County. The Contractor is responsible for maintaining documentation to evidence that drivers providing services have a valid Texas Driver's License and have completed a State approved "Safe Driving" course. Contractor must maintain documentation of the automobile liability insurance of each vehicle utilized by the program as required by state law. All vehicles must have a current Texas State Inspection. The minimum acceptable limit of automobile liability insurance is $300,000.00 combined single limit. Agency must maintain detailed records of mileage driven and names of

	individuals provided with transportation, as well as origin and destination of trips. ***It is the Contractor's responsibility to verify the County in which clients reside in.***
Staff Requirements	A picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting any clients. Drivers must have annual proof of a safe driving record, which shall include history of tickets, DWI/DUI, or other traffic violations. Conviction on more than three (3) moving violations within the past year will disqualify the driver. Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.
Special Requirements: **RWGA Only**	Individuals who qualify for transportation services through Medicaid are not eligible for these transportation services. **Contractor must ensure the following criteria are met for all clients transported by Contractor's transportation program:** Transportation Provider must ensure that clients use transportation services for an appropriate purpose through one of the following three methods: 1. Follow-up hard copy verification between transportation provider and Destination Agency (DA) program confirming use of eligible service(s), or 2. Client provides receipt documenting use of eligible services at Destination Agency on the date of transportation, or 3. Scheduling of transportation services was made by receiving agency's case manager or transportation coordinator. The verification/receipt form must at a minimum include all elements listed below: • Be on Destination Agency letterhead • Date/Time • CPCDMS client code • Name and signature of Destination Agency staff member who attended to client (e.g. case manager, clinician, physician, nurse) • Destination Agency date stamp to ensure DA issued form.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
3.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #3**	Date: **04/22/2020**
Recommendations:	Financial Eligibility: 400%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Vision Care**	
HRSA Service Category Title: **RWGA Only**	**Ambulatory/Outpatient Medical Care**
Local Service Category Title:	**Vision Care**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Corrective lenses are not allowable under this category. Corrective lenses may be provided under Health Insurance Assistance and/or Emergency Financial Assistance as applicable/available.
HRSA Service Category Definition: **RWGA Only**	***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. HRSA policy notice 10-02 states funds awarded under Part A or Part B of the Ryan White CARE Act (Program) may be used for optometric or ophthalmic services under Primary Medical Care. Funds may also be used to purchase corrective lenses for conditions related to HIV infection, through either the Health Insurance Premium Assistance or Emergency Financial Assistance service categories as applicable.
Local Service Category Definition:	**Primary Care Office/Clinic Vision Care** is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. A visit with a credentialed Ophthalmic Medical Assistant for any of the following is an allowable visit: • Routine and preliminary tests including Cover tests, Ishihara Color Test, NPC (Near Point of Conversion), Vision Acuity Testing, Lensometry. • Visual field testing • Glasses dispensing including fittings of glasses, visual acuity testing, measurement, segment height. • Fitting of contact lenses is not an allowable follow-up visit.

Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals residing in the Houston EMA/HSDA.
Services to be Provided:	Services must be provided at an eye care clinic or Optometrist's office. Services must include but are not limited to external/internal eye health evaluations; refractions; dilation of the pupils; glaucoma and cataract evaluations; CMV screenings; prescriptions for eyeglasses and over the counter medications; provision of eyeglasses (contact lenses are not allowable); and referrals to other service providers (i.e. Primary Care Physicians, Ophthalmologists, etc.) for treatment of CMV, glaucoma, cataracts, etc. Agency must provide a written plan for ensuring that collaboration occurs with other providers (Primary Care Physicians, Ophthalmologists, etc.) to ensure that patients receive appropriate treatment for CMV, glaucoma, cataracts, etc.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = One (1) patient visit to the Optometrist, Ophthalmologist or Ophthalmic Assistant.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	HIV-infected resident of the Houston EMA/HSDA.
Agency Requirements:	Providers and system must be Medicaid/Medicare certified to ensure that Ryan White Program funds are the payer of last resort to the extent examinations and eyewear are covered by the State Medicaid program.
Staff Requirements:	Vendor must have on staff a Doctorate of Optometry licensed by the Texas Optometry Board as a Therapeutic Optometrist.
Special Requirements: **RWGA Only**	Vision care services must meet or exceed current U.S. Dept. of Health and Human Services (HHS) guidelines for the treatment and management of HIV disease as applicable to vision care.

FY 2021 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/04/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2020**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/21/2020**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Council approved - 06-2019

TARGETING FOR FY 2020 SERVICE CATEGORIES FOR RYAN WHITE PART A, B, MAI AND STATE SERVICES FUNDING

HIV Prevalence	AIDS Prevalence	HIV & AIDS Prevalence	Geographic Targeting	Other Targeting	N/A or No Targeting	Service Category
			X*	X**		Ambulatory/Outpatient Medical Care
			X*	X		Case Management Services - Core
				X		Case Management Services - Non-Core
				X		Early Medical Intervention
					X	Emergency Financial Assistance - Pharmacy Assistance
					X	Health Insurance
					X	Home and Community Based Services
					X	Hospice Services
					X	Linguistic Services
					X	Local Pharmacy Assistance Program
					X	Medical Nutritional Therapy
					X	Mental Health Treatment
					X	Other Professional Services
					X****	Outreach Services - Primary Care Retention in Care
			X***		X	Oral Health
					X	Referral for Health Care & Support Services - ADAP Enrollment Worker
					X	Substance Abuse Treatment
			X	X		Transportation Services
					X	Vision

* Geographic targeting in rural area only.

** In an effort to provide a base line that reflects actual client utilization, for community based organizations base this percentage on the FY 2019 final expenditures that targeted African Americans, Whites and Hispanics.

*** Geographic targeting in the north only.

**** Pay particular attention to youth who are transitioning into adult care.

DATA USED TO JUSTIFY FY 2021 HOW TO BEST MEET THE NEED DECISIONS

2020 HHS Federal Poverty Guidelines

Effective Date: 01/15/2020

	Size of Family Unit							
Poverty Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
100%	12,760	17,240	21,720	26,200	30,680	35,160	39,640	44,120
133%	16,971	22,929	28,888	34,846	40,804	46,763	52,721	58,680
150%	19,140	25,860	32,580	39,300	46,020	52,740	59,460	66,180
200%	25,520	34,480	43,440	52,400	61,360	70,320	79,280	88,240
250%	31,900	43,100	54,300	65,500	76,700	87,900	99,100	110,300
300%	38,280	51,720	65,160	78,600	92,040	105,480	118,920	132,360
350%	44,660	60,340	76,020	91,700	107,380	123,060	138,740	154,420
400%	51,040	68,960	86,880	104,800	122,720	140,640	158,560	176,480
450%	57,420	77,580	97,740	117,900	138,060	158,220	178,380	198,540
500%	63,800	86,200	108,600	131,000	153,400	175,800	198,200	220,600

For family units with more than 8 members, add $4,480 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

Housing Profile

2020 Houston HIV Care Services Needs Assessment

Disclaimer:
This Housing Profile uses data from the 2020 Houston Area HIV Care Services Needs Assessment (approval pending). The 2020 Needs Assessment summarizes primary data collected from April 2019 to February 2020 from 589 self-selected, self-identified people living with HIV (PLWH) using either a self-administered written or electronic survey, or verbal interview. Most respondents resided in Houston/Harris County at the time of data collection. Data were statistically weighted for sex at birth, primary race/ethnicity, and age range based on a three-level stratification of HIV prevalence in the Houston EMA (2018). Though quality control measures were applied, limitations to the raw data and data analysis exist, and other data sources should be used to provide context for and to better understand the results. Data collected through this process represent the most current *primary* data source on PLWH in the Houston Area. Census, surveillance, and other data presented here reflect the most current data available at the time of publication.

Funding acknowledgment:
The 2020 Houston Area HIV Care Services Needs Assessment is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $24,272,961 and was not financed with nongovernmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government."

Incentives were provided by the Houston Regional HIV/AIDS Resource Group, Inc.

Suggested citation:
Housing Profile - 2020 Houston Area HIV Care Services Needs Assessment.
Approved: PENDING. Primary Author: Amber Lynn Harbolt, MA, Health Planner, Ryan White Planning Council Office of Support.

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HOUSING SERVICE NEEDS AND BARRIERS

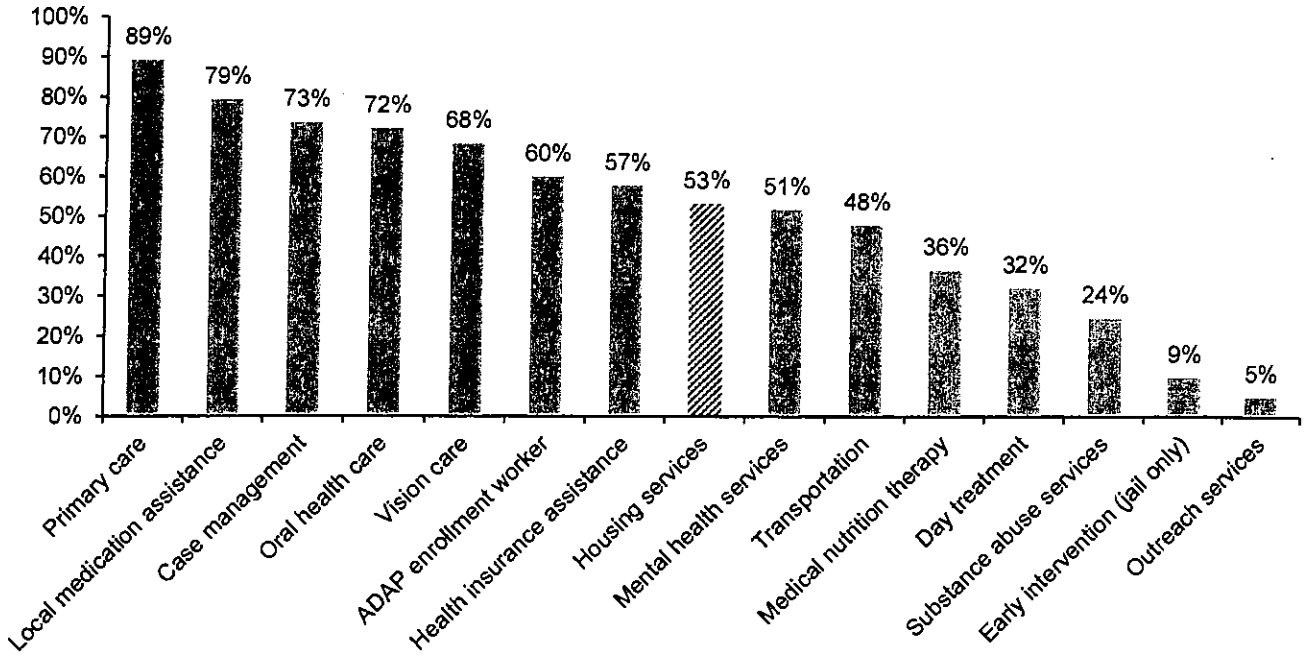
As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (**HOPWA**) program through the City of Houston Housing and Community Development Department and for PLWH recently released from incarceration through the Houston Regional HIV/AIDS Resource Group (**TRG**). The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (**HHD**) prevention program. This Profile assesses the need, accessibility, and barriers to housing for PLWH in the Houston area.

Overall Ranking of Housing and Funded Services, by Need

At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. For the first time, the 2020 Houston Area HIV Needs Assessment also collected data on the need for and accessibility to 10 additional services that are allowable under Ryan White, but not currently funded through Ryan White in the Houston area, such as housing services. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded and unfunded services they needed in the past 12 months.

(**Graph 1**) All funded and unfunded services except hospice and linguistics were analyzed and received a ranking of need. Housing services was identified as the most commonly needed unfunded service at 53% of survey participants indicating need. When ranked with currently funded services, housing was the 8th highest ranked for need. This places the need ranking for housing services before mental health services, transportation, medical nutrition therapy, adult day treatment, substance abuse services, early intervention services, and outreach services.

GRAPH 1-Ranking of Housing and Funded HIV Services in the Houston Area, By Need, 2020
Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator: 569-573 participants, varying between service categories



Overall Ranking of Housing and Funded Services, by Accessibility

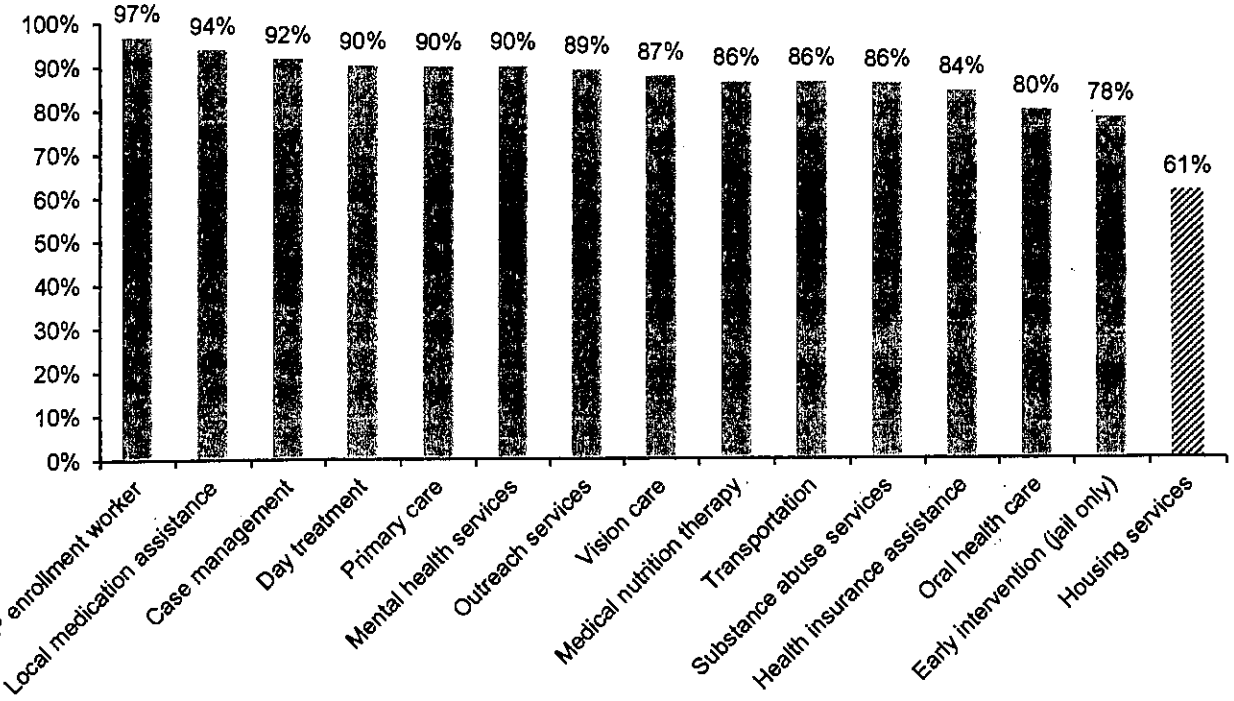
Participants were asked to indicate whether each of the funded and unfunded services they needed in the past 12 months was easy or difficult for them to access.

(**Graph 2**) All funded and unfunded services except hospice and linguistics were analyzed and received a ranking of accessibility. Housing was identified as the least accessible unfunded service as only 61% of the participants who needed housing services found it easy to access. When ranked with currently funded services, housing the lowest ranked for accessibility. This places the accessibility ranking for housing services below every funded and unfunded service.

GRAPH 2-Ranking of Housing and Funded HIV Services in the Houston Area, By Accessibility, 2020

Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.

Denominator: 569-573 participants, varying between service categories



Housing Services Need and Accessibility by Demographic Categories and Select Special Populations

(**Table 1 and Table 2**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For housing services, this analysis shows the following:

- More females than males found the service accessible.
- More Black/African American PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.

In addition, more transgender, homeless, and MSM PLWH found the housing difficult to access when compared to all participants.

TABLE 1 Housing Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not need service	48%	42%	53%	40%	55%	29%	70%	41%	53%
Needed, easy to access	31%	38%	24%	41%	24%	38%	30%	35%	28%
Needed, difficult to access	22%	19%	24%	19%	20%	33%	0%	24%	19%

TABLE 2 Housing Services, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not need service	23%	52%	52%	22%	80%	28%
Needed, easy to access	35%	25%	32%	8%	3%	28%
Needed, difficult to access	42%	23%	16%	9%	17%	44%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

Barriers to Accessing Housing Services

Since the 2016 Houston Area HIV Needs Assessment, participants who reported *difficulty* accessing needed services have been asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. In 2016, staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers, then grouped together into 12 nodes, or barrier types. This categorization schema was applied to reported barriers in the 2020 survey.

(**Table 3**) When barriers to housing services were reported, the most common barrier type was wait-related issues at 28% of reports, followed by education and awareness issues (24%), interactions with staff (13%), administrative issues (9%) and eligibility issues (6%). Wait-related issues most commonly experienced were being placed on a housing waitlist (often in excess of 2 years) or being told a waitlist for housing was unavailable. Education and awareness issues were most often lack of knowledge about housing service availability or where to go to access housing services. Barriers regarding interactions with staff were most often poor or no communication from staff and staff who were not knowledgeable about area housing resources. Administrative issues were almost exclusively long, complex, or confusing processes required for accessing housing services. Barriers related to eligibility were most often having difficulty obtaining documentation needed for housing eligibility.

TABLE 3: Top 5 Reported Barrier Types for Housing Services, 2020

	No.	%
1. Wait-related (W)	31	28%
2. Education and Awareness (EA)	27	24%
3. Interactions with Staff (S)	14	13%
4. Administrative (AD)	10	9%
5. Eligibility (EL)	7	6%

ADDITIONAL HOUSING DATA

The 2020 Houston Area HIV Needs Assessment collected additional data relevant to housing needs, homelessness, housing instability, and housing quality. These additional data are presented below.

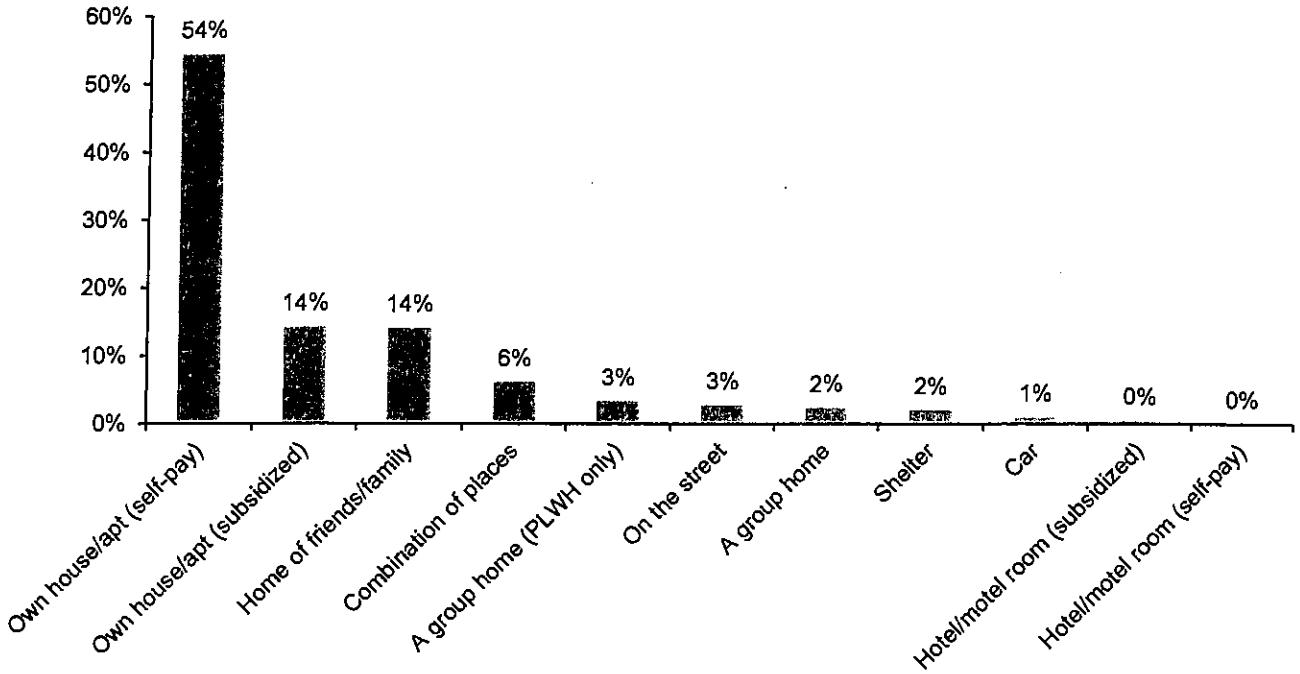
Housing Type, Homelessness, and Housing Instability

Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to select on response for where they sleep most often from a list of 11 possible housing types. Participants were also encouraged to write in where they sleep most often if they did not see it listed among the housing type options. Another question asked they felt their current housing situation was stable.

(**Graph 3**) A majority of participants slept most often in a house or apartment that they paid for (54%). This was followed by sleeping most often in a subsidized house or apartment (14%), staying with friends or family (14%), sleeping in a combination of places (6%) staying in a group home for PLWH (3%), or sleeping on the street (3%).

Participants who indicated they slept most often at a shelter, in a car, on the street, or in a combination of places that changes were identified as experiencing homelessness. By this metric, 11% of participants were experiencing homelessness as the time of survey. Regardless of housing type, 32% of participants indicated that they felt their current housing situation was unstable.

GRAPH 3 -Ranking of Housing Types for PLWH in the Houston Area, 2020
Definition: Percent of needs assessment participants stating they slept most often at each housing type.
Denominator: 563 participants



Current Housing Problems

Regardless of housing status and stability, other housing-related issues may present barriers to access and retention in care. Twelve-percent (12%) of participants indicated that their housing situation has interfered with them getting HIV medical care.

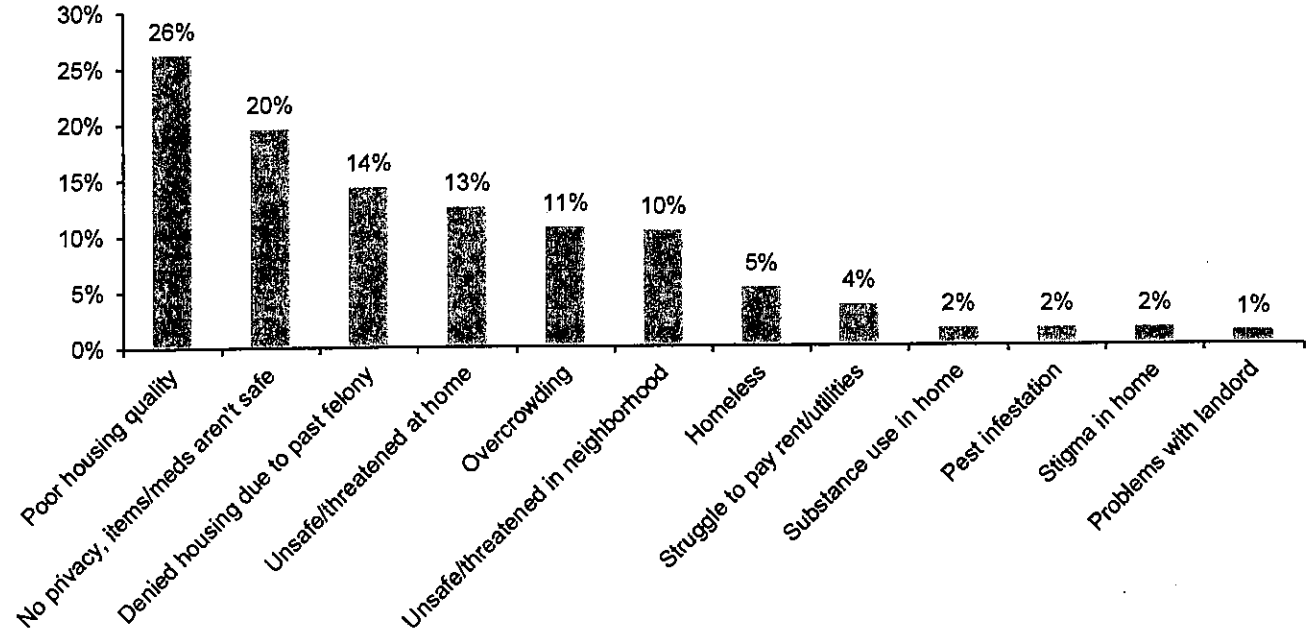
Participants were asked to indicate whether they were currently experiencing any of a list of housing quality, safety, or access issues. Participants were also encouraged to write-in any current housing problems, which at analysis were added to the list or condensed into existing options. Forty-percent (40%) of survey participants indicated they were currently experiencing housing quality, safety, or access issues.

(**Graph 4**) The most common housing problem participants were experiencing at the time of survey was poor housing quality at 26%. Examples given in the survey for poor housing quality were presence of mold or asbestos, exposed wires, broken windows, leaks, poor insulation, broken plumbing, or broken appliances. This was followed by having no privacy and feeling that possessions and medications were not safe (20%), being denied housing due to a past felony (14%), feeling unsafe or threatened at home (13%), and overcrowding (11%). Write-in responses with enough cases to justify inclusion in the list currently experiencing homelessness, struggling to pay rent/utilities, substance use in the home, pest infestation, stigma at home, and difficulties with landlords.

GRAPH 4-Current Housing Problems Experienced by PLWH, 2020

Definition: Of needs assessment participants stating they were currently experiencing problems with housing quality, safety, or access, the percent stating they were experiencing each problem.

Denominator: 328 participants



FY 2021 How to Best Meet the Need Justification for Each Service Category – Special Workgroup #2

DRAFT: 03/24/20

Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-20 *(In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than 5 p.m. on May 4, 2020. This form is available by calling the Office of Support 832 927-7926)*	
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Emergency Financial Assistance	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.)
Food Pantry (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
Legal Assistance	Contractor returned funds because they did not need them to provide the service. No other organization bid on the service.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Outreach Services	Significant alternative funding.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

‡ Service Category for Part B/State Services only.

How To Best Meet the Need FY 2006 Justification for Each Service Category (as of 06-15-05)

Service Category	Is this a core service? If no, how does this svc support access to core services?	A. Bundle Services? B. Elim. duplicative services/activities. C. Reduce svcs not directly related to assuring access to primary medical care. D. Make svc delivery more efficient	Documentation of Need: From the 2005 Needs Assessment (NA); 2002 Comp Plan (CP); 2004 Client Utilization Data (CUD); 2004 Outcome Measures (OM) and/or State of Emergency (SE)	Identify Alternative Funding Sources	Justify the use of Ryan White Title I funds for this service	Recommendation(s)
Part 1: Services offered by Title I in the Houston EMA as of 03-01-05						
Housing Assistance* QA Motion: (Caldwell, Boyle) to accept the workgroup recommendations. Votes: Y = 10; N = 0; Abstentions = 0	__Yes ✔ No		FY 04 OM: From 3/1/04 through 02/28/05 272 clients received Title I housing coordination. According to CPCDMS records, 180 of these clients (66.1%) accessed Title I/III/IV primary care at least once during this time period after utilizing housing coordination. 30% of clients who completed a baseline survey reported spending one or more nights outside in the past two weeks. 0% of clients who completed a follow-up survey reported spending one or more nights outside in the past two weeks. FY 04 CUD: Emergency Shelter Vouchers: # served: 183. Alloc/client: $737. Units/client: n/a. Disb/client: $702. Housing Related Services (Coor.): # served: 271. Alloc/client: $342. Units/client: 24. Disb/client: n/a. '05 NA: Rental Assistance: U: 14, N: 8, B: 1, G: 2; Emergency Shelter Vouchers: U: 37, N: 31, B: 9, G: 3 '03 CP: A1, A2, B1, B2, B3, C1	HOPWA, HUD COC and emergency shelter grants.	This service is not the purpose of Title I funds.	Eliminate Housing Assistance and Housing Related Services.
Housing Related Svcs (Housing Coordination) ***See Housing Assistance for motion.***	__Yes ✔ No		'05 NA: U: 24, N: 16, B: 3, G: 6	HOPWA, HUD COC and emergency shelter grants.	This service is not the purpose of Title I funds.	Eliminate Housing Assistance and Housing Related Services.

BRIDGE RE-ENTRY INITIATIVE (BRI)

FOR HOUSING NEWLY RELEASED INDIVIDUALS LIVING WITH HIV/AIDS

HOPWA Facility-Based Housing Assistance (FBHA)

SERVICE CATEGORY DEFINITION

- **Facility-Based Housing Assistance (FBHA)** - All eligible HOPWA housing assistance expenditures for or associated with supportive housing facilities including community residences, single-room occupancy (SRO) dwellings, short-term facilities, project-based rental assistance units, master leased units, and other housing facilities approved by HUD. The DSHS HOPWA Program limits the use of FBHA to Short-Term Supportive Housing (STSH) and Transitional Supportive Housing (TSH) services.
  - **Short-Term Supportive Housing (STSH)**- A type of facility-based housing assistance that provides temporary shelter to eligible households that are homeless. Services allow for an opportunity to develop an individualized housing plan to guide the household's linkage to permanent housing. Project Sponsors may provide assistance for up to 60 days in any six-month period. The amount of assistance varies per household depending on funds available, need, and program guidelines.
  - **Transitional Supportive Housing (TSH) Services-** A type of facility-based housing assistance that provides up to 24 cumulative months of rental assistance to eligible households that are homeless or at risk of homelessness. Services allow for an opportunity to move households to permanent housing. The subsidy amount is determined in part based on household income and rental costs associated with the household's lease.
- **Permanent Housing Placement (PHP) Services-** A supportive housing assistance service that helps establish the household in the housing unit, including but not limited to reasonable costs for security deposits not to exceed two months of rent costs.

PROGRAM ELIGIBILITY

HOPWA PROGRAM ELIGIBILITY

- At least one household member must be living with HIV (24 CFR §574.3);
- Household annual gross income cannot exceed 80 percent of area median income per the household's county of residence (24 CFR §574.3); and
- The household must reside in the Project Sponsor's HSDA (DSHS requirement).
- STSH the household must be homeless as defined by HUD
- TSH the household must be homeless or at risk of homelessness as defined b HUD

BRI PROGRAM ELIGIBILITY

- At least one household member must meet the definition of recently released (also called post-incarceration) as defined by the Project Sponsor FBHA program (released in the past 120 calendar days from HCJ or TDCJ);
- The eligible household must provide discharge documentation (absence of discharge documentation should not exclude a household, alternative verification methods as allowable)
- It is preferred/recommended the eligible household have a release date to be considered for participation

BRI PROGRAM

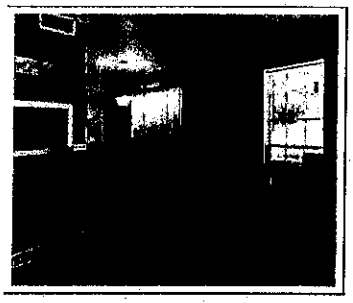
The vision of this project is to assist individuals re-entering society from a correctional facility with stable housing with access to medical care with the goal of maintaining viral load suppression.

Program Goals

1. Residential Stability
2. Maintenance in Medical Care (and support services as needed)
3. Increased Skills or Income
4. Increased self-efficacy

STSH PROGRAM

- Short-term facilities are intended to provide temporary shelter to eligible individuals to prevent homelessness and allow an opportunity to develop an individualized housing and service plan to guide the client's linkage to permanent housing.
- 60-day maximum stay

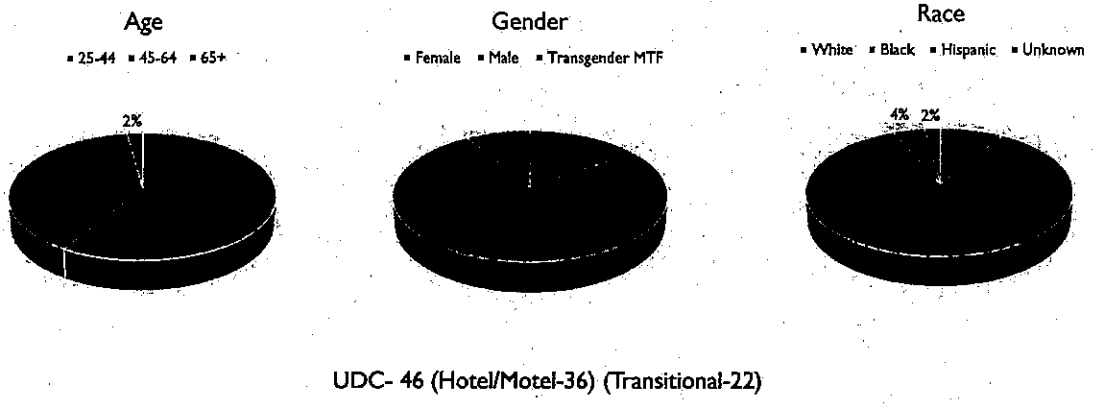


TSH PROGRAM

TSH provides up to 12-cumulative months of facility-based rental assistance to households that are homeless or at risk of homelessness, including assistance for shared housing arrangements. TSH allows households an opportunity to prepare for permanent housing and develop individualized housing plans that guide their linkage to permanent housing

- Please note HOPWA allows for up to 24-cumulative months for FBHA-TSH, project capped at 12-months

PROGRAM DEMOGRAPHICS (1/1/19-5/27/2020)



UDC- 46 (Hotel/Motel-36) (Transitional-22)

Houston Area HIV Services Ryan White Planning Council
Assessment of the Local Ryan White HIV/AIDS Program Administrative Mechanism
Assessment Checklist

(Quality Improvement Committee approved 05/07/20)

Background

The Ryan White CARE Act requires local Planning Councils to "[a]ssess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area" (Ryan White Part A [formerly Title I] *Manual*, Section V, Chapter 1, Page 4). To meet this mandate, a time-specific documented observation of the local procurement, expenditure, and reimbursement process for Ryan White funds is conducted by the local Planning Councils (*Manual*, Section VI, Chapter 1, Page 7). The observation process is not intended to evaluate either the local administrative agencies for Ryan White funds or the individual service providers funded by Ryan White (*Manual*, Section VI, Chapter 1, Page 8). Instead, it produces information about the procurement, expenditure, and reimbursement process for the local *system* of Ryan White funding that can be used for overall quality improvement purposes.

Process

In the Houston eligible area, an assessment of the local administrative mechanism is performed for each Fiscal Year of Ryan White funding using a written checklist of specific data points. Taken together, the information generated by the checklist is intended to measure the overall efficacy of the local procurement, reimbursement, and contract monitoring processes of the administrative agents for (1) Ryan White Part A and Minority AIDS Initiative (MAI) funds; and (2) Ryan White Part B and State Services (SS) funds. The checklist is reviewed and approved annually by the Quality Improvement Committee of the Houston Area HIV Services Ryan White Planning Council, and application of the checklist, including data collection, review, analysis and reporting, is performed by the Ryan White Planning Council Office of Support in collaboration with the administrative agents for the funds. All data and documents reviewed in the process are publicly available.

Checklist

The checklist for the assessment of the administrative mechanism for the Houston eligible area is attached below. The following acronyms are used in the checklist:

AA:	Administrative Agent
DSHS:	Texas Department of State Health Services
FY:	Fiscal Year (The FY to be assessed for Part A, B, and MAI will be the immediate prior FY, ending February 28 [Part A and MAI] and March 31 [Part B]; the FY to be assessed for SS will be the most recent completed FY.
MAI:	Minority AIDS Initiative
MOU:	Memorandum of Understanding (between the AAs and the Planning Council)
NGA:	Notice of Grant Award
PC:	Ryan White Planning Council
RFP:	Request for Proposals
SOC:	Standards of Care
SS:	State Services

Checklist for the Assessment of the Ryan White Administrative Mechanism in the Houston Area (Quality Improvement Committee approved 05-07-20)

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process			
• To assess the timeliness of the AA in authorizing contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	a) How much time elapsed between receipt of the NGA or funding contract by the AA and contract execution with funded service providers (i.e., 30, 60, 90 days)?	Part A/MAI: (1) NGA; and (2) Commissioner's Court Agendas Part B/SS: (1) DSHS Contract Face Sheet; and (2) Contract Tracking Sheet
• To assess the timeliness of the AA in procuring funds to contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	b) What percentage of the grant award was procured by the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC
• To assess if the AA awarded funds to service categories as designed by the PC	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	c) Did the awarding of funds in specific categories match the allocations established by the PC at the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC Final PC Allocations Worksheet
• To assess if the AAs make potential bidders aware of the grant award process	Confirmation of communication by the AAs to potential bidders specific to the grant award process	d) Does the AA have a grant award process which: ☐ Provides bidders with information on applying for grants? ☐ Offers a bidder's conference?	RFP Courtesy Notices for Pre-Bid Conferences
• To assess if the AAs are requesting bids for service category definitions approved by the PC	Confirmation of communication by the AAs to potential bidders specific to PC products	e) Does the RFP incorporate service category definitions that are consistent with those defined by the PC?	RFP
• To assess if the AAs are procuring funds in alignment with allocations	Comparison of final amounts procured and total amounts allocated in each service category	f) At the end of the award process, were there still unobligated funds?	Year-end FY Procurement Reports provided by AA to PC
• To assess if the AAs are dispersing all available funds for services and, if not, are unspent funds within the limits allowed by the funder	Review of final spending amounts for each service category	g) At the end of the year, were there unspent funds? If so, in which service categories?	Year-end FY Procurement Reports provided by AA to PC

Checklist for the Assessment of the Ryan White Administrative Mechanism in the Houston Area (Quality Improvement Committee approved 05-07-20)

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process (con't)			
• To assess if the AAs are making the PC aware of the procurement process	Confirmation of communication by the AAs to the PC specific to procurement results	h) Does the AA have a method of communicating back to the PC the results of the procurement process?	MOU PC Agendas
Section II: Reimbursement Process			
• To assess the timeliness of the AA in reimbursing contracted agencies for services provided	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	a) What is the average number of days that elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA? b) What percent of contractors were paid by the AA after submission of an accurate contractor reimbursement request or invoice: ☐ Within 20 days? ☐ Within 35 days? ☐ Within 50 days?	Annual Contractor Reimbursement Report
Section III: Contract Monitoring Process			
• To assess if the AA is monitoring adherence by contracted agencies to PC quality standards	Confirmation of use of adopted SOC in contract monitoring activities	a) Does the AA use the SOC as part of the contract monitoring process?	RFP Policy and Procedure for Performing Site Visits Quality Management Plan

2020 Quarterly Report
Quality Improvement Committee
(May 2020)

Status of Committee Goals and Responsibilities (*means mandated by HRSA)

1. Conduct the "How to Best Meet the Needs" (HTBMN) process, with particular attention to the continuum of care with respect to HRSA identified core services.
   Done

2. Develop a process for including consumer input that is proactive and consumer friendly for the Standards of Care and Performance Measures review process.

   There will be a consumer-only Standards of Care and Performance Measure workgroup in the Fall.

3. Continue to improve the information, processes and reporting (within the committee and also thru collaboration with other Planning Council committees) needed to:

   a. Identify "The Un-met Need"; ***Done***

   b. Determine "How to Best Meet the Needs"; ***Done***

   c. *Strengthen and improve the description and measurement of medical and health related outcomes. ***Done. See the Justification chart.***

4. *Identify and review the required information, processes and reporting needed to assess the "Efficiency of the Administrative Mechanism". Focus on the status of specific actions and related time-framed based information concerning the efficiency of the administrative mechanism operation in the areas of:

   a. Planning fund use (meeting RWPC identified needs, services and priorities);

   b. Allocating funds (reporting the existence/use of contract solicitation, contract award and contract monitoring processes including any time-frame related activity);

   c. Distributing funds (reporting contract/service/re-imbursement expenditures and status, as well as, reporting contract/service utilization information).

   The checklist for the next report has been approved.

5. Annually, review the status of committee activities identified in the current Comprehensive Plan.

   Delayed in 2020 due to COVID-19 and focus on the HTBMN process via Zoom.

Status of Tasks on the Timeline: ***On track.***

Committee Chairperson

5/7/20
Date

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FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need*: individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2018 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)

Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-17-2020

Ambulatory/Outpatient Primary Medical Care (incl. Vision):

CBO, Adult – Part A, Including LPAP, MCM, EFA, Outreach & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:*** *(Cruz/Vargas)* *Votes: Y=9; N=0;* *Abstentions= Miertschin, KMills, Padilla, Robison*	☑ Yes ☐ No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP	Epi (2018): An estimated 6,825 people in the EMA are HIV+ and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2019): # clients served: *Primary Care: 9,384* *(6% increase v. 2018)* *LPAP: 5,119*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	**Can we make this service more efficient?** No **Can we bundle this service?** Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage **Has a recent capacity issue been identified?** No	**Wg Motion:** Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none. **SEE QUALITY IMPROVEMENT COMMITTEE MINUTES FROM 05-07-20 FOR POSSIBLE ADDITOINAL CHANGES MADE TO EMERGENCY**

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*[†] to access primary care? *EIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		support maintenance/retention in care and viral suppression for PLWH.	*(9% increase v. 2018)* *Medical Case Mgmt: 5,396* *(11% decrease v. 2018)* *EFA: 1,527* *(146% increase v. 2018)* *Outreach: 779* *(23% increase v. 2018)* *Non-Medical Case Mgmt, or Service Linkage: 8,956* *(21% increase v. 2018)* Outcomes (FY2018): *Primary Care/LPAP:* 76% of Primary Care clients and 77% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 52% of clients were in continuous HIV care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 39% of clients	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant.	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan **Is this a duplicative service or activity?** - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-		**FINANCIAL ASSISTANCE.**

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *E.T.E.A.- Early Identification of individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *"Unmet Need"* - individuals diagnosed with HIV but with no evidence of care for 12 months. *"Continuum of Care"*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e. Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Service funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
			accessed HIV care w/in 3 mos.; 46% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	Covered under QHP? ✔ Yes ___No	related eligibility criteria, and (3) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA*: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. **Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. **Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Public Clinic, Adult – Part A, Including LPAP, MCM, EFA, Outreach & Svc Linkage (Includes OB/GYN) *See below for Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:*** *(Cruz/Vargas)* *Votes: Y=9; N=0;* *Abstentions= Miertschin, KMills, Padilla, Robison*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	Epi (2018): An estimated 6,825 people in the EMA are HIV+ and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Mahagement: #3* *Outreach: #14* Service Utilization (2019): # clients served: *Primary Care: 9,384* *(6% increase v. 2018)* *LPAP: 5,119* *(9% increase v. 2018)* *Medical Case Mgmt: 5,396* *(11% decrease v. 2018)* *EFA: 1,527*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA,	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need	**Can we make this service more efficient?** No **Can we bundle this service?** Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage **Has a recent capacity issue been identified?** No	**Wg Motion:** Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none. **SEE QUALITY IMPROVEMENT COMMITTEE MINUTES FROM 05-07-20 FOR POSSIBLE CHANGES MADE TO EMERGENCY FINANCIAL ASSISTANCE.**

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FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

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			Service Linkage: 46% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

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DRAFT: 04/29/20

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Service funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Rural, Adult – Part A, Including LPAP, MCM, EFA, Outreach & Svc Linkage (Includes OB/GYN) *See below for Pediatric, Vision* **Workgroup #1** *Motion: (Cruz/Vargas) Votes: Y=9; N=0; Abstentions= Miertschin, KMills, Padilla, Robison*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	Epi (2018): An estimated 6,825 people in the EMA are HIV+ and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2019): # clients served: *Primary Care: 9,384* *(6% increase v. 2018)* *LPAP: 5,119* *(9% increase v. 2018)* *Medical Case Mgmt: 5,396* *(11% decrease v. 2018)* *EFA: 1,527*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA,	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need	**Can we make this service more efficient?** No **Can we bundle this service?** Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage **Has a recent capacity issue been identified?** No	**Wg Motion:** Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none. **SEE QUALITY IMPROVEMENT COMMITTEE MINUTES FROM 05-07-20 FOR POSSIBLE CHANGES MADE TO EMERGENCY FINANCIAL ASSISTANCE.**

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EHE/A Early Identification of Individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e. Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
			(146% increase v. 2018) *Outreach: 779* *(23% increase v. 2018)* *Non-Medical Case Mgmt, or Service Linkage: 8,956* *(21% increase v. 2018)* Outcomes (FY2018): *Primary Care/LPAP:* 76% of Primary Care clients and 77% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 52% of clients were in continuous HIV care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 39% of clients accessed HIV care w/in 3 mos.; 46% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or*	and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	- Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan **Is this a duplicative service or activity?** - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*‡ to access primary care? *EI/HA: Early identification of individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care *"Unmet Need"* Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care*: The continuum of interventions that begin with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a resource capacity issue been identified?	Recommendation(s)
			Service Linkage: 46% of clients were in continuous HIV care following Service Linkage <u>Pops. with difficulty accessing needed services</u>: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*‡ to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e. Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients, b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Pediatric – Part A ***Workgroup #1*** ***Motion:*** *(Cruz/Vargas)* *Votes: Y=9; N=0;* *Abstentions= Miertschin, KMills, Padilla, Robison*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Continuum of Care: Primary Care, MCM, and Service Linkage support maintenance/retention in care and viral suppression for PLWH.	Epi (2018): An estimated 6,825 people in the EMA are HIV+ and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2019): # clients served: *Primary Care: 9,384* *(6% increase v. 2018)* *LPAP: 5,119* *(9% increase v. 2018)* *Medical Case Mgmt: 5,396* *(11% decrease v. 2018)* *EFA: 1,527*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic.	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with Medical Case Management and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state,	**Can we make this service more efficient?** No **Can we bundle this service?** Currently bundled with: Medical Case Management and Service Linkage **Has a recent capacity issue been identified?** No	**Wg Motion:** Add the allowability of telehealth and telemedicine to the service definition, update the justification chart, and keep the financial eligibility the same: PriCare=300%, MCM=none, SLW=none, Outreach=none.

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EHE A: Early Identification of individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2018 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
			(146% increase v. 2018) *Outreach: 779* *(23% increase v. 2018)* *Non-Medical Case Mgmt, or Service Linkage: 8,956* *(21% increase v. 2018)* Outcomes (FY2018): *Primary Care/LPAP:* 76% of Primary Care clients and 77% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 52% of clients were in continuous HIV care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 39% of clients accessed HIV care w/in 3 mos.; 46% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or*	Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan **Is this a duplicative service or activity?** - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
			Service Linkage: 46% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS*, seeks to identify the status unaware and link them into care *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Vision – Part A ***Workgroup #1*** ***Motion:*** *(Cruz/Ledbetter)* *Votes: Y=12; N=0;* *Abstentions= Hawkins, KMills*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Vision services support maintenance/ retention in HIV care by increasing access to care and treatment for HIV-related and general ocular diagnoses. Untreated ocular diagnoses may act as logistical or financial barriers to HIV care.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:#5 Service Utilization (2019): # clients served: 2,865 *(12% increase v. 2018)* Outcomes (FY2018): 11 diagnoses were reported for HIV-related ocular disorders, all of which were managed appropriately Pops. with difficulty accessing needed services: Females (sex at birth), Other/multiracial, 18-24, Homeless, OOC	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *QHPs cover pediatric vision	No known alternative funding sources exist for this service	**Can we make this service more efficient?** No **Can we bundle this service?** Currently bundled with Primary Care **Has a recent capacity issue been identified?** No	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Clinical Case Management - Part A ***Workgroup #1:*** ***Motion:*** *(Cruz/Hawkins)* *Votes: Y=7; N=0;* *Abstentions= Miertschin, KMills, Padilla, Robison, Sanchez, Vargas*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care, making CCM is a strategy for preventing unmet need. CCM also addresses local priorities related to mental health and substance abuse co-morbidities Continuum of Care: CCM supports maintenance/ retention in care and viral suppression for PLWH.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:#3 Service Utilization (2019): # clients served: 1,316 *(15% increase v. 2018)* Outcomes (FY2018): 50% of clients were in continuous care following receipt of CCM. 79% of clients utilizing CCM were virally suppressed. Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	RW Part C EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ___Yes ✔ No	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #2 service need by PLWH - Results in desirable health outcomes for clients who access the service - Prevents unmet need by addressing co-morbidities related to substance abuse and mental health - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan **Is this a duplicative service**	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

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Service Category	Is this a core service? If no, how does the service support access to core services & support client achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seek to identify the status unaware and link them into care *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2015 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
					or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		
Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup #1*** ***Motion:*** *(Cruz/Hawkins)* *Votes: Y=9; N=0;* *Abstentions= Miertschin, KMills, Padilla, Robison*	___Yes ✔No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:#3 Service Utilization (2019): # clients served: 180 *(2% decrease v. 2018)* Outcomes (FY2018): Following Service Linkage, 46% of clients were in continuous HIV care, and	RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning	**Justify the use of funds:** This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state,	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*‡ to access primary care? *EI/HA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		goal of linkage to HIV medical care ≤ 3 months of diagnosis. In 2015, 19% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	49% accessed HIV primary care for the first time Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ___Yes ✔ No	and local goals related to linkage to care **Is this a duplicative service or activity?** - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care *Unmet Need: Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade	Documentation of Need (Sources of Data include: 2020 Needs Assessment; 2017-2021 Comp Plan; 2016 Ending the HIV Epidemic Plan; 2018 Outcome Measures; 2018 Chart Reviews; Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation($)
Early Intervention Services (EIS)‡ (Incarcerated) (Harris County Jail) ***Workgroup #3*** ***Motion:*** *(Cruz/Hawkins)* *Votes: Y=10; N=0;* *Abstentions=none.*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Local jail policy mandates HIV testing within 14 days of incarceration, thereby identifying status-unaware members of this population. In 2017, an estimated 180 PLWH were released from TDCJ into Harris County. During incarceration, 100% are linked to HIV care. EIS ensures that the newly diagnosed identified in jail maintain their HIV care post-release by bridging re-entering PLWH into community-based primary care. This is accomplished through care coordination by EIS staff in partnership with community-based	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#13* Service Utilization (2019): # clients served:677 *(14% decrease v. 2018)* Chart Review (2019): Of the client records reviewed, 97% of clients had a discharge plan present and 9% of all client records reviewed had documentation that the client accessed HIV care after release. Pops. with difficulty accessing needed services: Other / multiracial, White, 25-49, RR, Homeless, Transgender, MSM	RW Part C provides non-targeted EIS EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ___Yes ✔ No	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Results in desirable outcomes for clients who access the service - Links those newly diagnosed in a local EMA jail to community-based HIV primary care upon release, thereby maintaining linkage to care for and preventing unmet need in this Special Population - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan **Is this a duplicative service or activity?**	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need*: individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		providers/MOUs. Unmet Need: PLWH re-entering the community are at risk of lapsing their HIV care upon release from incarceration. EIS helps to prevent unmet need among this population by bridging re-entering PLWH into community-based primary care post-release. This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs. Continuum of Care: EIS supports linkage to care, maintenance/retention in care and viral suppression for PLWH.			- No, there is no known alternative funding for this service as designed		

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

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Service Category	Is this a core service? If no, how does this service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *"EIIHA" Early identification of individuals with HIV/AIDS seeks to identify the status, unaware and link them into care* *"Unmet Need" Individuals diagnosed with HIV but with no evidence of care for 12 months* *"Continuum of Care" The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade*	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Emergency Financial Assistance							**See Quality Improvement Committee Minutes from 05-07-20 for possible additional changes to this service category.**
Health Insurance Premium & Co-Pay Assistance **Part A** **Part B** **State Services** ***Workgroup #2*** *Motion: (Cruz/Pradia)* *Votes: Y=12; N=0;* *Abstentions=KMills.*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Reductions in unmet need can be aided by *preventing* PLWH from lapsing their HIV care. This service category can directly prevent unmet need by removing financial barriers to HIV care for those who are eligible for public or private health insurance. Currently,	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: #7 *% of RW clients with health insurance: 37%* *% of RW clients with Marketplace coverage: 4%* Service Utilization (2019): # clients served: 2,274	No known alternative funding sources exist for this service, though consumers between 100% and 400% FPL may qualify for Advanced Premium Tax Credits (subsidies). COBRA plans seems to have fewer out-of-pocket costs. Covered under QHP?	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to	**Can we make this service more efficient?** Yes, see attached service definitions for changes. **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Add text to the service definition that states clients should receive notification that payments have been made to and received by their insurance provider, update the justification chart, and keep the financial eligibility the same: 0 - 400%, ACA plans: must have a subsidy.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care. *Unmet Need: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers. Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		42% of RW clients have some form of health insurance, and 6% have Marketplace coverage. This service will assist those clients to remain in HIV care via all insurance resources; This will also be utilized to assist federal health insurance marketplace participants. Continuum of Care: Health Insurance Assistance facilitates maintenance/ retention in care and viral suppression by increasing access to non-RW private and public medical and pharmaceutical coverage. The savings yielded by securing non-RW healthcare coverage for PLWH increases the amount of funding available to provide	*(3% increase v. 2018)* Outcomes (FY2018): 81% of health insurance assistance clients were virally suppressed Pops. with difficulty accessing needed services: Other / multiracial, HL, 25-49, Transgender, Homeless, MSM, Rural	___Yes ✔ No	retention in care and reducing unmet need - Supports federal health insurance marketplace participants **Is this a duplicative service or activity?** - No, there is no known alternative funding for this service as designed		

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIIHA: Early identification of individuals with HIV/AIDS seeks to identify the status-unaware and link them into care.* *Unmet Need: Individuals diagnosed with HIV but with no evidence of care for 12 months.* *Continuum of Care: The continuum of intervention that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.*	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation($)
		other needed services throughout the Continuum of Care.					
Home and Community-Based Services‡ (Facility-based) (Adult Day Treatment) *Workgroup #3* ***Motion:*** *(Pradia/Crawford)* *Votes: Y=9; N=0;* *Abstentions=Stacy.*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Adult Day Treatment contributes to this goal by providing a community-based alternative to in-patient care facilities for those with	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#11* Service Utilization (2018): # clients served: 27 *(39% decrease v. 2018)* Chart Review (2019): 82% of clients records had a complete care plan based on	Medicaid Covered under QHP? ___Yes ✔ No	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service; and use has increased - Results in desirable health outcomes for clients who access the service - Helps prevent unmet need for those with advanced HIV-related health concerns - Facilitates national, state,	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If not, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*‡ to access primary care? ‡*EIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. ‡*Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. ‡*Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		advanced HIV-related health concerns. This, in turn, may prevent those with advanced stage illness or complex HIV-related health concerns from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. In addition, the goal of Adult Day Treatment is to return clients to self-sufficient daily functioning, which includes maintenance in HIV care. <u>Continuum of Care</u>: Adult Day Treatment facilitates re-linkage and retention in care for PLWH by providing a community-based alternative to in-patient care facilities for those with advanced HIV-related health concerns, and may prevent those with advanced HIV-related health	the primary medical care provider's order. 90% of records had evaluation of health, psychosocial, functional, & home env. status <u>Pops. with difficulty accessing needed services</u>: Other / multiracial, 25-49, Transgender, Homeless		and local goals related to retention in care, reducing unmet need, and viral load suppression **Is this a duplicative service or activity?** - This service is funded locally by one other public source for those meeting income or disability-related eligibility criteria		

‡ Service Category for Part B/State Services only.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and Surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		concerns from falling out-of-care.					
Hospice ‡ *Workgroup #3* ***Motion:** (Pradia/Hawkins)* *Votes: Y=9; N=0;* ***Abstentions=Stacy.***	✔ Yes __No	☐ EIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Hospice contributes to this goal by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis. This, in turn, may prevent PLWH from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. Hospice ensures clients with co-morbidities remain in HIV care. As a result, this service also addresses local priorities	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020):N/a Service Utilization (2019): # clients served: 28 *(39% decrease v. 2018)* Chart Review (2019): 92% of charts had records of palliative therapy as ordered and 100% had medication administration records on file. Records indicated that bereavement counseling was offered to client's family in 10% of applicable cases. Pops. with difficulty accessing needed services: N/a	Medicaid, Medicare Covered under QHP? ✔ Yes __No	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Prevents unmet need among PWA and those with co-occurring conditions - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan **Is this a duplicative service or activity?** - This service is funded	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*‡ to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e. Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		related to mental health and substance abuse co-morbidities. Continuum of Care: Hospice services support re-linkage and maintenance/retention in care for PLWH by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis, preventing PLWH from falling out of care.			locally by other public sources for those meeting income, disability, and/or age-related eligibility criteria		
Linguistic Services‡ ***Workgroup #3*** ***Motion:*** *(Hawkins/Ruggerio)* *Votes: Y=9; N=0;* *Abstentions=Crawford.*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. By eliminating language barriers in RW-funded HIV care, this service facilitates entry into care and	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020):N/a Service Utilization (2019): # clients served: 54 *(8% increase v. 2018)* *54% of Linguistics clients were African American / African origin and 31% were*	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients Covered under QHP? ___Yes ✔ No	**Justify the use of funds:** This service category: - Is a HRSA-defined Support Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby contributing to EIIHA goals	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** There is no waiting list at this time; however, the need for	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care. *Unmet Need: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		helps prevent lapses in care for monolingual PLWH. Continuum of Care: Linguistic Services support linkage to care, maintenance/retention in care, and viral suppression by eliminating language barriers and facilitating effective communication for non-Spanish monolingual PLWH.	*Asian American / Asian origin* Pops. with difficulty accessing needed services: N/a		and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Linguistic and cultural competence is a Guiding Principle of the Comprehensive HIV Plan **Is this a duplicative service or activity?** - No, there is no known alternative funding for this service as designed	this service has the potential to exceed capacity due to new cohorts of languages spoken in the EMA/HSDA	
Medical Nutritional Supplements and Therapy - Part A *Workgroup #2* *Motion: (Mica/Hawkins)* *Votes: Y=10; N=2;* *Abstentions= KMills.*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: The most commonly cited reason for referral to this service by a RW clinician is to mitigate side effects from HIV medication. Currently, 8% of	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#10* Service Utilization (2019): # clients served: 491	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *Some QHPs may cover prescribed supplements	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #9 service need by PLWH - Has limited or no alternative funding source - Results in desirable health	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?**	**Wg Motion:** Accept the service definition as presented, update the justification chart, and increase the financial eligibility to 400%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EHIA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		PLWH report that side effects prevent them from taking HIV medication. This service category eliminates potential barriers to HIV medication adherence by helping to alleviate side effects. In addition, evidence of an ART prescription is a criterion for met need. Continuum of Care: Medical Nutrition Therapy facilitates viral suppression by allowing PLWH to mitigate HIV medication side effects with supplements, and increasing medication adherence.	*(3% decrease v. 2018)* Outcomes (FY2018): 67% of medical nutritional therapy clients with wasting syndrome or suboptimal body mass improved or maintained their body mass index. 85% of Medical Nutritional Therapy clients were virally suppressed Pops. with difficulty accessing needed services: Females (sex at birth), Black/AA, 25-49, Homeless		outcomes for clients who access the service - Removes barriers to HIV medication adherence, thereby facilitating national, state, and local goals related to viral load suppression **Is this a duplicative service or activity?** - Alternative funding for this service may be available through Medicaid.	No	

‡ Service Category for Part B/State Services only.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIIHA*: Early identification of individuals with HIV/AIDS seeks to identify the status unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Mental Health Services‡ (Professional Counseling) ***Workgroup #2*** ***Motion:*** *(Cruz/Vargas)* *Votes: Y=12; N=0;* *Abstentions= Leisher.*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Of 29% of 2016 Needs Assessment participants who reported falling out of care for >12 months since first entering care, 9% reported mental health concerns caused the lapse. Over half (57%) of participants recorded having a current mental health condition diagnosis, and 65% reported experiencing at least one mental/emotional distress symptom in the past 12 months to such an extent that they desired professional help. Mental Health Services offers professional counseling for those with a mental health condition/concern, and, as a result, may help reduce	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#8* Service Utilization (2019): # clients served: 288 *(33% increase v. 2018)* Chart Review (2019): 96% of clients had treatment plans reviewed and/or modified at least every 90 days. 100% of charts reviewed contained evidence of appropriate coordination across all medical care team members Pops: with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, RR, Rural,	RW Part D (targets WICY), Medicaid, Medicare, private providers, and self-pay Some services provided by MHMRA Covered under QHP? ✔ Yes ___No	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #7 service need by PLWH - Facilitates national, state, and local goals related to retention in care and preventing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and (as a result of the motion) addresses certain Special Populations named in the Plan **Is this a duplicative service or activity?** - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY),	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same: 400%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e. Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		lapses in HIV-care. Mental Health Services also address local priorities related to mental health co-morbidities. Continuum of Care: Mental Health Services facilitate linkage, maintenance/ retention in care, and viral suppression by helping PLWH manage mental and emotional health concerns that may act as barriers to HIV care.	Homeless		(2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		
Oral Health Untargeted – Part B Rural (North) – Part A ***Workgroup #2*** ***Motion:*** *(Pradia/Cruz)* *Votes: Y=10; N=2;* *Abstentions= Stacy.*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Oral Health services support maintenance in HIV care by increasing access to care and treatment for HIV-related and general oral health diagnoses. Untreated oral	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: #4 Service Utilization (2019): # clients served: 3,830 *(7% increase v. 2018)*	In FY12, Medicaid Managed Care expanded benefits to include oral health services Covered under QHP*? ___Yes ✔ No *Some QHPs cover pediatric dental; low-cost add-on dental coverage can be	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #4 service need by PLWH. **Is this a duplicative service or activity?** - This service is funded locally by one other public	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** Yes, clients report waiting lists for this service	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*‡ to access primary care? *EHE/HAE Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care *Unmet Need:* Individuals diagnosed with HIV/not virally suppressed or out of care for 12 months *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2018 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and Surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation (5)
		health diagnoses can create poor health outcomes and may act as a financial barrier to HIV care.	Outcomes (FY2018): Oral Health Care – Rural Target: 100% of client charts had evidence of vital signs assessment, 96% had evidence of hard and soft tissue examinations, 97% had evidence of receipt of periodontal screening, and 99% had evidence of oral health education. Oral Health Care – Untargeted: 99% had chart evidence for vital signs assessment at initial visit, 99% had updated health histories in their chart, 89% had a signed dental treatment plan established or updated within the last year, and 75% had chart evidence of receipt of oral health education including smoking cessation.	purchased in Marketplace	sources for its Managed Care clients only		

‡ Service Category for Part B/State Services only.

Service Category	How does this service address individual's needs and barriers to access	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicative funding or the need to fill a gap	Identify the use of RSA Service Category, Part A, Part B and State Services funds for the service	Service Efficiency	Recommendation(s)
		Poor, with difficulty accessing needed services; Females (sex at birth), Other / multiracial, (White, 25-49), CADE, PSH, Mead			

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*[*] to access primary care? *EIIHA: Early identification of individuals with HIV/AIDS* seeks to identify the status unaware and link them into care *Unmet Need:* individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a). Clients b). Provider Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Referral for Health Care and Support Services‡ *Workgroup #1* ***Motion:*** *(Cruz/Ledbetter)* *Votes: Y=9; N=0;* *Abstentions=KMills, Padilla, Robison*	___Yes ✔No Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites will fund one FTE ADAP enrollment worker per Ryan White Part A primary care site. Each ADAP enrollment worker will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with submission of complete, accurate ADAP applications, as well as appropriate re-certifications and attestations.	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Assistance submitting complete and accurate ADAP applications and re-certifications reduces unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medication coverage. Continuum of Care: Increased access to HIV medication coverage supports medication adherence and viral suppression.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#6* Service Utilization (2019): # clients served: 6,286 *(73% increase v. 2018)* Chart Review (2019): 59% of AEW client had charts documented evidence of benefit applications completed as appropriate within two weeks the eligibility determination date. 59% had evidence of assistance provided to access health insurance or Marketplace plans. 73% had evidence of completed secondary reviews of ADAP applications before	Beyond assistance offered in the provision of case management care coordination, there is currently no funding to support dedicated ADAP Enrollment Workers at Ryan White primary care sites. Covered under QHP? ___Yes ✔No	**Justify the use of funds:** This service category: - Is a HRSA-defined Support Service - State Services-Rebate (SS-R) funding is intended to ensure service continuation or bridge service gaps. - ADAP medication coverage reduces use of LPAP funding. **Is this a duplicative service or activity?** No	**Can we make this service more efficient?** Placement of ADAP Enrollment Workers at each Ryan White primary care site will make this service more efficient and accessible than placement at a single site. **Can we bundle this service?** N/a – this would be the only use of SS-R funding in the Houston EMA/HSDA **Has a recent capacity issue been identified?** No	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category‡	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e. Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
			submission to THMP Pops. with difficulty accessing needed services: Other / multiracial, White, 50+, MSM, Homeless, Transgender, Rural, RR				
Substance Abuse Treatment – Part A ***Workgroup #2*** ***Motion:*** *(Pradia/Cruz)* *Votes: Y=10; N=2;* *Abstentions= Stacy, Leisher.*	☑ Yes ☐ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care. Therefore, Substance Abuse Treatment services can directly prevent or reduce unmet need. Substance Abuse Treatment also addresses local priorities	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#12* Service Utilization (2019): # clients served: 27 *(4% increase v. 2018)* Outcomes (FY2018): 57% of clients accessed	RW Part C, Medicaid, Medicare, private providers, and self-pay. Some services provided by SAMHSA Covered under QHP? ☑ Yes ☐ No	**Justify the use of funds:** This service category: - Is a HRSA-defined Core Medical Service - Removes potential barriers to early entry into HIV care, thereby contributing to EIIHA goals - Prevents unmet need by addressing the #2 cause cited by PLWH for lapses in HIV care - Facilitates national, state,	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

Service Category	Is this a core service? If not, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EHE*: Early identification of individuals with HIV/AIDS seeks to identify the status-unaware and link them into care *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		related to substance abuse co-morbidities. <u>Continuum of Care</u>: Substance Abuse Treatment facilitates linkage, maintenance/retention in care, and viral suppression by helping PLWH manage substance abuse that may act as barriers to HIV care.	primary care at least once after receiving Substance Abuse Treatment services and 69% were virally suppressed. <u>Pops. with difficulty accessing needed services</u>: Black/AA, 18-24, RR, Homeless		and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan **Is this a duplicative service or activity?** - This service is funded locally by other public and private sources for (1) those meeting income, disability, and/or age-related eligibility criteria, and (2) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA*: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care. **Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. **Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the "Continuum of HIV Care or Care Treatment Cascade."	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B, non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Case Management – Non-Medical - State Services (Targeting Substance Use Disorders) ***Workgroup #2*** ***Motion:*** *(Hawkins/Pradia)* *Votes: Y=11; N=0;* *Abstentions= Stacy, Leisher, Sanchez.*	___Yes ✔No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 3 months of diagnosis. In 2015, 19% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank of all types of case management w/in funded services: #3 Service Utilization (2019): Service delivery began on September 1, 2019 Pops. with difficulty accessing needed services: *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	This service was previously funded under SAMHSA. Covered under QHP? ___Yes ✔No	**Justify the use of funds:** This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care **Is this a duplicative service or activity?** - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		**Wg Motion:** Add the allowability of telehealth to the service definition, update the justification chart, and keep the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care*‡ to access primary care? *"EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care. *"Unmet Need:* individuals diagnosed with HIV but with no evidence of care for 12 months. *"Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2019 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and Surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.					
Transportation – Pt A (Van-based, bus passes & gas vouchers) ***Workgroup #3*** ***Motion:*** *(Cruz/Pradia)* *Votes: Y=10; N=0;* *Abstentions=none.*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Lack of transportation is the *fourth* most commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation services eliminate this barrier to care, thereby supporting PLWH in continuous HIV care.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#9* Service Utilization (2019): # clients served: *Van-based: 923* *(7% increase v. 2018)* *Bus pass: 2,203*	Medicaid, RW Part D (small amount of funds for parking and other transportation needs), and by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria. Covered under QHP*? ___Yes ✔ No	**Justify the use of funds:** This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need among Support Services by PLWH - Results in clients accessing HIV primary care - Removes potential barriers to entry/retention in HIV	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Wg Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 400%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If not, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care* to access primary care? *EIIHA: Early identification of individuals with HIV/AIDS* seeks to identify the status unaware and link them into care. *Unmet Need*: Individuals diagnosed with HIV but with no evidence of care for 12 months. *Continuum of Care*: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		Continuum of Care: Transportation supports linkage, maintenance/retention in care, and viral suppression by helping PLWH attend HIV primary care visits, and other vital services.	*(4% decrease v. 2018)* Outcomes (FY2018): 64% of clients accessed primary care at least once after using van transportation; and 35% of clients accessed primary care after using bus pass services. Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, Homeless, OOC, RR		care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need **Is this a duplicative service or activity?** - This service is funded locally by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.		

‡ Service Category for Part B/State Services only.

FY 2021 How to Best Meet the Need Justification for Each Service Category

DRAFT: 04/29/20

Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-17-20 *(In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than 5 p.m. on May 4, 2020 This form is available by calling the Office of Support: 832 927-7926)*	
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Food Pantry (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

‡ Service Category for Part B/State Services only.

Priority and Allocations Committee Report

DRAFT

Proposed Idea

THIS PAGE IS FOR THE PRIORITY AND ALLOCATIONS COMMITTEE
(See Criteria and Principles to Guide Decision Making)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY AND INCLUDE A BRIEF HISTORY OF RELATED SERVICE CATEGORY, IF AVAILABLE.

CURRENTLY APPROVED RELATED SERVICE CATEGORY ALLOCATION/UTILIZATION:
Allocation: $_____
Expenditure: $_____ Year-to-Date

Utilization: _____ Unduplicated Clients Served Year-to-Date
_____ Units of Service Provided Year-to-Date

AMOUNT OF FUNDING REQUESTED:
$_____This will provide funding for the following purposes which will further the objectives in this service category: (describe how):

PLEASE STATE HOW THIS IDEA WILL MEET THE PRIORITY AND ALLOCATIONS CRITERIA AND PRINCIPLES TO GUIDE DECISION MAKING. SITE SPECIFIC STEPS AND ITEMS WITHIN THE STEPS:

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

___ Recommended for Funding in the Amount of: $_____
___ Not Recommended for Funding
___ Other:

REASON FOR RECOMMENDATION: