NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

SERVICE STANDARDS

Nevada Ryan White Program B and Nevada Medication Assistance Program
Las Vegas, Nevada

Contents

SECTION I: UNIVERSAL STANDARDS

Eligibility

Six (6) month and Annual Recertification [HIV/AIDS Bureau Policy Clarification Notice (PCN #21-02)]
The Health Resources and Services Administration (HRSA) Ryan White legislation requires that individuals receiving services through Nevada Ryan White Part B (RWPB) must have a diagnosis of HIV, reside in Nevada, and be 400% below the Federal Poverty Level (FPL). Additionally, RWPB funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source. The Recipient, Nevada Office of HIV, will monitor procedures to ensure that all funded sub-recipients verify and document client eligibility and insurance status per the Ryan White Part B Universal Eligibility Manual.

For both initial/annual and six-month recertification procedures, eligibility determinations may be performed simultaneously with testing and treatment. Recipients and subrecipients assume the risk of recouping any HRSA RWPB funds utilized for clients ultimately determined to be ineligible, and instead charge an alternate payment source, or otherwise ensure that funds are returned to the HRSA RWPB program.

Ryan White funds are intended to support only the HIV-related needs of eligible individuals. The objectives of the eligibility determination are to:

- Establish client eligibility before providing services.
- Ensure all clients adhere to biannual (twice a year) recertification requirements.
- Collect basic applicant information to facilitate client identification, follow-up, and HRSA required performance measurements.
- Inform the applicant of services that are available and what the client can expect if they are determined eligible for services.
- Refer to the applicant for case management and other services and programs, if eligible.

The following persons may apply for services:

- Any individual seeking services.
- The individual's legal guardian.
- A person designated in the individual's medical power of attorney (i.e., their court-appointed representative or legal representative). Proper documentation must be collected at initial determination and re-determination to verify guardianship or medical power of attorney.

NOTE: Minors Seeking Services: Minors (under 18 years old) may receive services. Those seeking services without parental consent will be determined on a case-by-case basis with the approval of Ryan White Program Administrators.

To be considered an eligible client, someone applying must meet the following criteria:

- Live in Nevada.
- Have a documented diagnosis of HIV/AIDS.
- Have a household income that is at or below 400% of the federal poverty level (FPL).

Services will be provided to all clients without discrimination based on: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, prior medical history, or any other basis prohibited by law.

REQUIRED ELIGIBILITY DOCUMENTATION TABLE

Eligibility Requirement	Initial Eligibility Determination	Recertification 6-month	Recertification Once a Year/12-Month Period
HIV Diagnosis	Documentation required for Initial Eligibility Determination: • See application for acceptable documentation	No documentation required	No documentation required
Income	Documentation required for Initial Eligibility Determination: • See application for acceptable documentation	• Self-attestation of no change • Self-attestation of change - Recipient must require documentation of change in eligibility status	• Recipient requires a full application and associated documentation
Residency	Documentation required for Initial Eligibility Determination: • See application for acceptable documentation	• Self-attestation of no change • Self-attestation of change - Recipient must require documentation of change in eligibility status	• Recipient requires a full application and associated documentation

It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part B Universal Eligibility Manual in accordance with HRSA/HAB regulations. Eligibility must be completed at least once every six (6) months.

Guidance on Complying with the Payor of Last Resort Requirement:

- RWPB Recipients and Subrecipients must ensure that reasonable efforts are made to use non RWPB resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify any other possible payers to extend finite RWPB funds.
- RWPB Recipients and Subrecipients must maintain policies and document their efforts to ensure that they assist clients to vigorously pursue enrollment in health care coverage and that clients have accessed all other available public and private funding sources for which they may be eligible.
- RWPB Recipients and Subrecipients can continue providing services funded through RWPB to a client who is unenrolled in other health care coverage so long as there is documentation that such coverage was pursued, i.e., Medicaid, loss of employer sponsored coverage, COBRA.
- RWPB Recipients and Subrecipients should conduct periodic checks to identify any potential changes to clients' healthcare coverage that may affect whether the RWPB is the Payor of Last Resort and require clients to report any such changes.

Agency Enrollment Status Option Definitions:

- Active means a client is eligible and receiving services.
- Inactive/Case Closed- is for when a client stops coming to your agency and after you have completed your agency's outreach attempts to retain that client in care, or you are notified by the client that they no longer need your agency's services.
- Incarcerated – this option is most often used when your agency is notified that a client identifies as incarcerated. Some agencies treat this option differently depending on their funding and population needs. If you are unsure, check with your agencies policies and protocols.
- Referred or Discharged – This should be selected when a client is referred to another provider, maybe to another Ryan White Agency to meet their needs or have been discharged from your agencies services because they have completed their program and no longer need your agencies services.
- Relocated – is when a client has moved and is no longer receiving services from your agency, often when a client moves outside of your agency's service area.
- Removed – is for when a client has violated your agency's rules or conduct requirements and has essentially been fired as a client with your agency.
- "Mini-Mod" is only available for clients that are not RWPA eligible (EHE Applications). This will allow the user to update Demographics, Race/Ethnicity, Diagnosis, Labs, Services, Medications (Poverty, Insurance & Annual Screenings). This allows for the collection of data elements needed for RSR.

Payor of Last Resort:
Once a client is eligible to receive RWPB services, the RWPB is considered the Payor of Last Resort, and as such, funds may not be used for any item or service to the extent that payment has been made, or can reasonably be expected to be made under:

- Any State compensation program

- An insurance policy, or under any Federal or State health benefits program
- An entity that provides health services on a pre-paid basis

Each agency providing services will have a case closure protocol. The reason for case closure must be properly documented in each client's chart.

Discharge, Transition, Case Closure

Subrecipients are responsible for educating clients of their rights and responsibilities, confidentiality policies, and informing clients of the agency's grievance policy at the time of intake within all Ryan White funded services and annually thereafter. If a client is discharged or case closure occurs, the provider must reasonably attempt to contact the client to inform the client of their pending discharge/case closure.

Discharge/ Termination of Care Planning
Unplanned discharge from *medical or non-medical case management services* may affect the client's ability to receive and stay compliant with medical care. Therefore, it is mandatory that at least *three (3)* attempts be made over no more than a three (3) month period to contact the clients who appear to be lost to follow-up (e.g., those who haven't had an appointment with the agency for a period of twelve months or more in moderate services or three (3) months or more in intensive services). Clients who cannot be located after three (3) attempts shall receive a formal letter by mail explaining their reason for discharge. A client may be discharged from medical or non-medical case management services for any of the following conditions:

Note: Date of discharge, reason, and any recommendations for follow-up shall be documented in the client's record and the medical care provider is notified.

- The client is deceased.
- The client has become ineligible for services (e.g., due to relocation outside the Transitional Grant Area/TGA or fails to meet other eligibility criteria).
- The client no longer demonstrates the need for case management due to their own ability to effectively advocate for their needs.
- Client's medical condition improves, and Medical Nutrition Therapy/MNT services are no longer necessary.
- The client chooses to terminate services.
- The client's needs would be better served by another agency.
- The client is/or becomes incarcerated.
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.
- The client cannot be located after documented three attempts for a period of no less than three months (90 days).
- The Client is utilizing services improperly.

- The client is transitioning into another level of case management services within the RWPB system. In this case to ensure a smooth transition, relevant intake documents may be forwarded to the new service provider and case managers from both agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained.

Client Rights and Responsibilities

Services will be provided to all eligible RWPB clients without discrimination based on: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Subrecipient's providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each Subrecipient will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

Privacy and Confidentiality (including securing records)
RWPB funded agency must maintain client confidentiality as well as maintain files and data in a secure manner. These requirements include the documentation of engagements between the client and provider, policies pertaining to electronic and paper file security, quality assurance activities related to the maintenance of files, and the archiving of files.

Personnel

All staff and supervisors will have a written job description with specific minimum requirements for their positions that align with the service category in which the agency is providing. Clinical staff must be licensed or registered as required. Agencies are responsible for ensuring all staff are licensed and registered for all service categories that require clinical personnel as well as providing staff with supervision and training to develop capacities needed for effective job performance.

Staff and program supervisors will receive consistent administrative supervision. Administrative supervision addresses issues related to staffing, policy, client documentation, reimbursement, scheduling, training, quality enhancement activities, and the overall operation of the program and/or agency. Clinical staff will receive clinical supervision. All supervision addresses any issue directly related to client care and job-related stress (e.g., boundaries, crisis, and burnout).

Any staff that is considered "other health care staff" positions will need prior approval by the grantee regarding the qualifications of these positions to ensure compliance with the approved program model as well as within the scope of allowable credentials approved by HRSA.

All RWPB funded providers are to adhere to service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual RWPB subgrant to meet the expectations of their deliverables.

These service specific standards shall be followed by all funded providers/staff that provide RWPB funded Services. It is expected that all providers/staff follow these standards as well as the National Monitoring Standards and HRSA PCNs. Provider organizations and staff may exceed any of these standards as part of the program delivery.

Program Safety

Services are provided in settings that comply with local, state, and federal regulations to ensure the well-being of clients and staff, whether on-site, off-site, or during operations pertaining to the services (i.e., transportation).

- Facilities are clean, comfortable, and free from hazards; and
- Facilities are accessible to clients, including children (when appropriate) and/or people with disabilities.

- This section left blank -

SECTION II: CORE MEDICAL SERVICES

- This section left blank -

Health Insurance Premium and Cost Sharing Assistance (HIP-CS)

SERVICE CATEGORY DEFINITION

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

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

To use Ryan White HIV/AIDS Program (RWHAP) funds for standalone dental insurance premium assistance, a RWHAP Part B recipient must implement a methodology that incorporates the following requirement:

RWHAP Part B recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

The Nevada Office of HIV (OoH) has done a cost analysis and has determined that it is more effective to purchase dental insurance for clients than it is to pay the full cost of HIV dental services.

OoH recommends that all subrecipients utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the RWPB Recipient RWPB, and we will provide necessary guidance. It is an expectation that all agencies implement a program that can produce measurable, positive effects for clients.

Service Goals and Objectives

The Service Category for HIP-CS is Health Insurance Program (HIP).

Health Insurance Premium and Cost Sharing Program Assistance (HIP-CS)
The service goal and objective of the cost-sharing assistance and premium payment program is to provide persons living with HIV the opportunity to receive primary/specialty care, dental, and vision services for monitoring and maintenance of their HIV for overall health. For the purposes of this service category, in alignment with the HRSA Service Definition, RWPB will fund cost-sharing assistance and premium payments to provide comprehensive health care services for eligible clients enrolled in a Marketplace Health Insurance plan or to provide

standalone dental insurance premium payments to receive medical and pharmacy benefits under a health care coverage program. RWPB will also fund payment of pseudo-insurance products for medical to provide eligible clients with comprehensive medical coverage.

There is a service cap per grant year of $3,000 per enrolled client for HIP-CS services. There will be no exceptions to this policy. There is a service cap per grant year of $400 per enrolled client for vision frames and lenses. Please be advised that the $400 service cap for vision frames and lenses is included in the $3,000 overall HIP-CS service cap per grant year.

Currently Funded
Health Insurance Premium and Cost Sharing Services

- Dental Insurance Premium Payment
- HIP-CS Claim Payment (Medical)
- HIP-CS Claim Payment (Dental)

A client MUST be RWPB eligible to receive the following services:

1. *Dental Insurance Premium Payment:*
   - A dental insurance premium payment made to an approved dental insurance provider for an insured client's dental service(s).
2. HIP-*CS Claim Payment (Medical):*
   - A co-payment and/or deductible payment to a medical provider for an insured client's HIV related medical service(s).
3. HIP-*CS Claim Payment (Dental):*
   - A co-payment and/or deductible payment to a dental provider for an insured client's HIV related dental service(s).

HIP-CS Services Eligibility
Before services are provided under this Service Category, provider agency staff must ensure current RWPB eligibility enrollment by using the CAREWare's Eligibility and Enrollment Fields tab.

The following eligibility criteria are specific to HIP-CS Services:

- The client has been referred to a RWPB HIP-CS services provider from another RWPB funded program.
- Has sought out assistance of the agency through self-referral.
- Has received a referral from an outside RWPB provider.

<u>If the client is referred to the HIP-CS Services Provider from a non-RWPB provider, the HIP-CS Services Provider is responsible for notifying the originating non-RWPB provider that the client is now accessing services and the HIP-CS Services Provider is responsible for logging the referral in CAREWare.</u>

Service Delivery
RWPB funds may only be used to pay for any Ryan White HIV/AIDS Program services not covered or partially covered by the client's private health plan. RWPB cost-sharing assistance funds may not be used to pay for services that are out-of-network unless the client is receiving services that could not have been obtained from an in-network provider.

RWPB HIP-CS funds may be used to make past-due premium, co-pay, and deductible payments so long as the client is eligible on the date of the requested service (i.e. the day the request is made for the past-due premium payment), if the payment is cost effective in the aggregate, and if the past-due bill is not in collections. These payments can only be made for past-due premiums, co-pays, and deductibles for insurance that include at least one drug in each class of antiretroviral therapeutics and appropriate out-patient ambulatory services.

For prospective premium payments, if a health insurance plan requires payment for a period of time such as a quarterly or binder payment, HIP-CS funds may be used for payment of that period of time that may in certain instances exceed the client's current eligibility period. For example, a client requests payment of a Medicare Part D insurance premium, which provides coverage for an entire quarter from January to March, but the client is only eligible from January 1st to February 28th. In this instance, HIP-CS funds may be used to pay for this quarterly premium payment.

Personnel Qualifications (including licensure)
Health Insurance Program and Cost Sharing Assistance Program coordination and processing services are provided by non-medical personnel who have at least six months of relevant experience in any of the areas of outreach work, community services, supportive work with families and individuals, aging, supportive work with youth, corrections, fiscal services, or public relations. The minimum educational experience shall be a high school degree or General Educational Development (GED). It is highly recommended that personnel responsible for reviewing and approving qualifying premium payment, deductible payment, co-payments, and membership fee payments have relevant medical, coding, billing, and/or fiscal experience. If qualified individuals do not have relevant and current experience related to working with individuals living with HIV, they must receive HIV specific training within six months of hire.

References and further reading
Federally approved clinical guidelines for the treatment of HIV
HIV/AIDS Bureau – National Monitoring Standards for Ryan White Part B Grantees: Program – Part B HIV/AIDS Bureau – Policy Clarification Notice 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Use of Funds
Las Vegas TGA – Ryan White Part A HIV/AIDS Program, Service Standards
Nevada Office of HIV/AIDS Policy Eligibility & Enrollment for Ryan White Part B
Ryan White HIV/AIDS Program Service Report Instruction Manual.

Program Guidance:
Traditionally, RWHAP Parts A and B recipients have supported health insurance premiums and cost sharing programs. If a RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place, and it must be cost-effective.

See below:
PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance
PCN 13-04: Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance
PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid
PCN 14-01: Revised 4/3/2015: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

Note: *Nevada RWPB uses the Federal Formula Part B Grant to fund the Health Insurance Premium and Cost-Sharing Assistance Program for dental care insurance premiums, dental care insurance co-payments, and HIV-related medical co-payments (non-Rx).*

Medical Case Management

SERVICE CATEGORY DEFINITION

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

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

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

Program Guidance: Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be

considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

OoH recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Nevada Recipient Office and we will provide necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on clients.

Currently Funded Medical Case Management Activities

- Initial Assessment/Development
- Reassessment/Redevelopment
- Referral and Related Activities
- General Monitoring
- Treatment and Adherence Counseling (MCM)
- Discharge Planning for MCM

Service Delivery

Initial Assessment/Development (MCM) [Item A]

Comprehensive assessment of individual needs, to determine the need for any medical, educational, social, or other services. Case Management assessments will include an evidence-based screening tool to be conducted on clients during intake and on an annual basis to determine referrals into substance abuse, mental health services, or other services.

Development of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities ensuring active participation of the individual and others in developing goals; and identifies a course of action to respond to the needs of the individual.

Reassessment/Redevelopment (MCM) [Item B]

Comprehensive reassessment individual needs, to determine the need for any medical, educational, social, or other services. A reassessment should be done no sooner than six months after the previous assessment. Case Management assessments will include an evidence-based screening tool to be conducted on clients during intake and on an annual basis to determine referrals into substance abuse, mental health services, or other services.

Periodic revision of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities ensuring active participation of the individual and others in developing goals; and identifies a course of action to respond to the needs of the individual.

Referral and Related Activates (MCM) [Item C]

Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other

programs and services that can provide needed services to address identified needs and achieve goals specified in the care plan.

General Monitoring [Item D]
The case manager should engage in continuous contacts to assess the client's response to the care plan. This can be in collaboration with the client, family or caregiver, or providers of services. The case manager should be in contact regularly with the client to be aware of any changes in the client's medical condition, service needs, or life events.

Treatment Adherence Counseling (MCM) [Item E]
Contacts made under Treatment Adherence Counseling are specifically to advise clients via telephone, digital, in-person, etc. about the importance of adherence to medication treatments, primary and specialty doctor visits, and laboratory visits. Treatment Adherence Counseling is to be done by and with the Medical Case Manager or Case Management Team in a non-outpatient setting.

Discharge Planning for MCM [Item F]
A medical case management agency that utilizes *individualized care plans* may use Discharge Summary for a variety of options, such as: to indicate the client has satisfactorily met the goals of their care plan, the client has moved out of jurisdiction, the client is no longer in need of medical case management, the client is lost to care or can no longer be located, the client's needs are more appropriately addressed in another program such as medical case management, the client exhibits a pattern of abuse as defied by agency's policy, or the client has deceased.

To determine if a client is lost to care or cannot be located, the subrecipient will attempt and document three (3) follow-up contacts over a period of time, i.e., contacts are not to be conducted on the same day. Examples of a client being lost to care or cannot be located include: the client is non-responsive to agency contacts regarding referral follow-up, or the client is non-responsive to agency attempts to complete a 60-day general monitoring check-in. The reason for a discharge summary must be notated in CAREWare within the service notes.

Personnel Qualifications (including licensure)
Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services.

Any staff that is considered "other health care staff" positions will need prior approval by the grantee regarding the qualifications of these positions to ensure compliance with the approved program model as well as within the scope of allowable credentials approved by HRSA.

Registered Nurses and Licensed Social Workers are the primary professional staff that are designed to be a Medical Case Manager.

References and further reading
All Part B funded providers should read their individual Part B contracts, as well as but not limited to, the Quality Management Plan and all local policies and guidelines set forth by the Part B office regarding the Part B program statewide. All referenced materials for standards are listed under the Universal Programmatic and Administrative National Monitoring Standards.

AETC National Resource Center for Case Management Activities for Persons Living with HIV.
Federally approved clinical guidelines for the treatment of HIV
HIV/AIDS Bureau – National Monitoring Standards for Ryan White Part B Grantees: Program – Part B
HIV/AIDS Bureau – Policy Clarification Notice 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Use of Funds
Las Vegas TGA – Ryan White Part A HIV/AIDS Program, Service Standards
Nevada Office of HIV/AIDS Policy Eligibility & Enrollment for Ryan White Part B
Ryan White HIV/AIDS Program Service Report Instruction Manual, December 2021

Medical Nutrition Therapy

SERVICE CATEGORY DEFINITION

The Health Resources Services Administration (HRSA), defines Medical Nutrition Therapy (MNT) to include:

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

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

Program Guidance: All activities performed under this service category must be pursuant to a medical care provider's referral and based on a nutritional plan developed by the Registered Dietitian or other licensed nutrition professional. Activities not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

The State of Nevada recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Recipient Office and we will provide the necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on our clients.

Currently Funded Medical Nutrition Activities

- Nutritional Education/Counseling
- Nutritional Supplements
- Nutrition Assessment and Screening

- Medical Nutrition Monitoring
- Medical Nutritional Plan

Service Delivery

Nutritional Education/Counseling [Item A]

Individualized and/or group dietary instructions that incorporate diet therapy counseling for a nutrition-related problem. This level of specialized instruction is above basic nutritional counselling and includes an individualized dietary assessment performed by a Registered Dietician (RD). Client nutritional health education will be offered to each client in a group or individual setting, topics may include, but are not limited to:

- Basic nutrition needs.
- Special dietary needs of people with HIV/AIDS.
- Coping with complications.
- Food and water safety.
- Drug Food Interactions.
- Developing a nutritional plan; and
- One-on-one nutritional counseling.

Dietician may also provide clients with referrals to specialized health care providers/services as needed to augment clients' needs that includes, but are not limited to:

- Other medical professionals such as social workers, mental health providers, or case managers.
- Community resources such as food pantries; SNAP/food stamps; Women, Infants and Children Supplemental Food Program (WIC), etc.
- Exercise facilities.
- Other education and economic resource groups.

Nutritional Supplements [Item B]

Services include providing nutritional supplement provisions deemed medically necessary and based on a medical care provider's recommendation. Upon receipt of the written referral by the medical care provider to the RD, clients may receive up to a 90-day supply of nutritional supplements at one time in accordance with their MNT developed nutritional plan. Nutritional supplements must be outlined in the written nutrition plan by the RD. Nutritional supplements which may directly affect HIV/co-morbidities includes:

- Caloric Supplements
- Fiber Supplements
- Multivitamin Supplements

Nutrition Assessment and Screening [Item C]

An initial MNT assessment will be conducted by a RD pursuant to a medical provider's referral. Clients will have a comprehensive initial intake and assessment by a registered dietician. The assessment shall include:

- Medical considerations.
- Food/dietary restrictions, including religions based, allergies, intolerances, interactions between medications, food, and complimentary therapies.
- Diet history and current nutritional status, including current intake.
- Macro- and micro-nutritional supplements.
- Height and weight, weight trends, goal weight, ideal body weight and % ideal body weight.
- Lean body mass and fat %.
- Waist and hip circumferences.
- Food preparation capacity; and
- Food preferences and cultural components of food.

The dietician will contact the patient for the initial nutritional assessment within five (5) business days of the referral. The initial assessment must be completed within ten (10) business days of the initial appointment.

Medical Nutrition Monitoring [Item D]
Medical Nutrition Monitoring and evaluation shall be conducted by the dietitian to determine the degree to which progress is made toward achieving the goals of the medical nutritional plan.

Medical Nutritional Plan [Item E]
Following the assessment, dietitians will take the information they've gathered in the assessment and provide patient-centered goals and individualized nutrition recommendations in the nutritional plan. A care plan based on the initial assessment includes:

- Developing and implementing a nutrition care plan.
- Providing nutrition counseling and nutrition therapy.
- Distributing nutritional supplements, when appropriate.
- Providing nutrition and HIV trainings to consumers; and
- Distributing nutrition related education materials to consumers.

A nutritional plan will be developed appropriate for the client's health status, financial status, and individual preference. A Nutritional Plan is completed within ten (10) business days of Nutrition Assessment. Required content of the Medical Nutritional Plan, includes:

- Nutritional diagnosis.
- Measurable goals.
- Recommended services and course of medical nutrition therapy to be provided, including the types and amounts of nutritional supplements and food provided, quantity, and dates.
- Date service is to be initiated.
- Planned number of and frequency of sessions.
- Date of reassessment.

- Any recommendations for follow-up; and
- Termination date of Medical Nutrition Therapy.

The plan will be signed by the Registered Dietician developing the plan. The Nutrition Plan will be updated as necessary, but no less than at least twice per year, and will be shared with the client, the client's primary medical care provider, and other authorized personnel involved in the client's care.

Process
The Service Standards provide a step-by-step process for conducting Medical Nutritional activities. The process steps below provide additional information in implementing these roles.

A. Before services are provided under this Service Category, subrecipient staff must ensure current Ryan White Part B enrollment through CAREWare' s Eligibility and Enrollment Fields tab.

B. All recommendations for Medical Nutritional Therapy Services must come from one of the following:
   - Medical Physicians(s), or
   - Nurse Practitioner(s), or
   - Physician Assistant(s), or
   - Advanced Practice Registered Nurse(s) (APRN), or
   - Registered Nurse(s).

C. Timelines: All completed nutritional plans and follow-up documents must be documented in a client's file by the subrecipient for review by the Recipient.

D. Medical Nutrition Plan: All clients receiving Medical Nutritional Therapy will be provided services pursuant to a medical care provider's recommendation, and a Medical Nutrition Plan developed by a licensed registered dietitian who will conduct an initial assessment of each client.

   - Subrecipients shall ensure that the licensed registered dietitian consults with each client's medical care provider prior to designing a dietary plan specific to the clients' needs.
   - Subrecipients shall ensure that clients receive individual nutritional assessments, nutritional follow-up counseling as needed, therapeutic diets, and nutritional information.
   - Subrecipients shall ensure that an individualized nutritional plan is developed for each individual seen, including an assessment of over the counter and prescribed medications regimen of each client as it relates to his/her nutritional needs. This plan shall further reflect the needs, circumstances, and food preferences of each client.

E. Client Records: Subrecipients shall ensure that the staff person providing nutritional

services be responsible for maintaining clients' records in relation to this program. Records will include, but not be limited to a minimum of:

- The individual client nutritional/dietary plan.
- Nutritional progress notes for each client counseling session conducted under this contract.
- Progress notes connected with the follow-up sessions shall indicate client progress in following the recommendations of their dietary plan.
- Obtains and documents HIV primary medical care provider contact information for each patient.
- MNT services must be provided in consultation with the medical care provider for medical coordination.
- MNT provider collects and documents assessment history information with updates as medically appropriate prior to providing care.

F. Medical Nutrition Monitoring: RD's shall ensure that they assess changes in nutritional intake for participating clients. RD follow ups may include review of client information, such as:

- relevant laboratory data.
- nutrition prescription or desired outcome.
- diagnosis and medical history.
- medications.
- need for additional nutrition education and counseling.
- alternative and complementary therapies.
- living situation; and
- any other relevant information that may impact a consumer's ability to care for him or herself.

Personnel Qualifications (including licensure)
The Medical Nutritional Therapy program must be administered by a RD Licensed in the State of Nevada.

Mental Health Services

SERVICE CATEGORY DEFINITION

Funding of Comprehensive Mental and Behavioral Health Services that include psychological and psychiatric treatment and counseling services offered to persons living with HIV with a diagnosed mental illness, substance use disorder, or co-occurring disorder conducted in a group or individual setting, based on a detailed treatment plan, and provided by a licensed professional or authorized facility within the State to provide such services.

Substance Use Disorder services (outpatient) are medical or other treatment and/or counseling to address substance use problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other

qualified personnel. They include limited support of acupuncture services to HIV-positive clients, provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists. Co-occurring disorders are often referred to as “dual disorders” or “dual diagnosis” in which an individual has co-occurring mental health and substance use disorders.

The State of Nevada recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Grantee Office and we will provide the necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on clients.

Currently Funded Mental Health service items:

A) Screening/Assessment
B) Mental Health Group Counseling
C) Mental Health Individual Counseling
D) Psychiatric Medication Management

Service Delivery

Screening/Assessment (Mental Health) [Items A]

Providing mental health and/or substance use screening and counseling interventions in the clinic aids in addressing untreated Behavioral Health concerns which can negatively impact a client’s ability to engage in HIV treatment. Treatment plans should be created for all clients in clinic sessions. The Mental Health provider should develop a treatment plan based on the screening and comprehensive assessment. This should be completed on intake but no later than within the first three appointments with the mental health provider.

The facility must document that the following assessments are completed prior to the development of an Individual Program Plan (IPP) and/or Service Plan; re-admission assessments must document the following information from the date of last service:

- Assessment of current functioning according to presenting problem, including history of the presenting problem, assessments must include a clinically supported screening tool (including but not limited to WHO Disability Assessment Schedule (WHODAS), Screening, Brief Intervention, and Referral to Treatment (SBIRT), Kessler 6, Kessler 10, M3 Checklist, The Healthy Living Questionnaire)
- Basic medical history, including any drug usage, a determination of the necessity of a medical evaluation, and a copy, where applicable of the results of the medical evaluation.
- Assessment information, including employment and educational skills; financial status; emotional and psychological health; social, family and peer interaction; physical health; legal issues; community living skills and housing needs; and the impact of alcohol and/or drug abuse or dependency in each area of the service recipient’s life functioning; and
- If necessary, a history of prescribed medications, over the counter medications used frequently, and alcohol or other drugs, including patterns of usage.

A written Plan of Care and/or Service Plan must be developed prior to the initiation of services with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

An Individual Program Plan and/or Service Plan must be developed and documented for each service recipient within thirty days of admission or by the end of the third face-to-face treatment contact with qualified alcohol and drug abuse personnel, whichever occurs first, and must include:

- The service recipient's name
- The date of the care plan's development
- Standardized diagnostic formulation(s) including, but not limited to, the current Diagnostic and Statistical Manual (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) and American Society of Addiction Medicine- Patient Placement Criteria for the Treatment of Substance-Related Disorders. (ASAM PPC)
- Specified service recipient problems which are related to specified problems, and which are to be addressed within the service/program component.
- Interventions addressing goals.
- Planned frequency of contact
- Signatures of appropriate staff; and
- Documentation of the service recipient's participation in the treatment planning process.

Treatment plans should be detailed including dates for measurable goal completion and continued treatment progress on the plan documented in the progress notes. All treatment plans will be reviewed every 90 days.

Staff should keep progress notes which include written documentation of progress or changes occurring within the care plan must be made in the individual service recipient record for each treatment contact.

The facility must review and, if indicated, revise the care plan at least every ninety days. The revision shall document any of the following which apply:

- Change in goals and objectives based upon service recipient's documented progress or identification of any new problems.
- Change in primary counselor assignment.
- Change in frequency and types of services provided; and
- A statement documenting review and explanation if no change is made in the IPP and/or Service Plan

Reassessment is an ongoing process that may occur throughout the process of receiving this service. At least once annually the client must complete a reassessment including the client's need for this service and review/update of the care plan and/or Service Plan. The purpose of

the reassessment is to address the issues noted during the monitoring phase. Reassessment must occur at the time of the IPP and/or Service Plan monitoring. Reassessment includes the following elements:

- Updating signatures and/or documentation from intake and screening to include confidential releases, eligibility requirements and contractual agreements per stated standards.
- Updating assessment per stated standards.
- Updating/ revising written plan of care and/or Service Plan per stated standards
- Communication with client regarding services.
- Entries in the written plan of care and/or Service Plan.
- Client acknowledgment of changes resulting from the reassessment.

Couples counseling can be recorded as service items A or E with service notes indicating that the service was provided to benefit the Individual client living with HIV in a couples counseling format.

Mental Health Group Counseling [Item B]
Group therapy can provide opportunities for increased social support vital to those isolated by HIV. Group therapy may be part of an individual's treatment plan, with progress being recorded in the individual's chart. Consideration shall be given to the composition of the group such that the client feels comfortable with the group. Group therapy can be provided in a variety of formats including psychotherapy groups, support groups, and drop-in groups. Groups may be led by a single leader or two co-facilitators. Psychotherapy Groups must be conducted by at least one licensed mental health practitioner. Support groups and drop-in groups must be conducted by at least one licensed mental health practitioner or an intern working toward licensure. Master's and Doctorate-level student interns may not conduct group therapy unless it is co-facilitated by a licensed mental health practitioner or an intern working toward licensure. Treatment provision is documented through summary notes, which will include the date and signature of the mental health practitioner. Summary notes completed by master's or Doctorate level student interns will be co-signed by licensed clinical supervisor.

Mental Health Individual Counseling [Item C]
Individual counseling/therapy is one-on-one individual counseling with the client and a trained, mental health professional. Treatment provision is documented through summary notes, which will include the date and signature of the mental health practitioner. Summary notes completed by master's or Doctorate level student interns will be co-signed by licensed clinical supervisor.

Psychiatric Medication Management [Item D]
Psychiatric medication management is a level of outpatient treatment where the sole service rendered by a qualified medical staff is the initial evaluation of the patient's need for psychotropic medications, the provision of a prescription, and as-needed, ongoing medical monitoring/evaluation related to the patient's use of the psychotropic medication. Interactive psychotherapy cannot be rendered under this service unit.

Personnel Qualifications (including licensure)

Mental Health services can be provided by a psychiatrist; licensed Medical Doctor (MD); licensed psychologist; licensed psychiatric nurses; licensed nurses; licensed clinician: Marriage and Family Therapist (M.F.T), Licensed Clinical Social Worker (L.C.S.W), Doctor of Philosophy (PhD) or doctorate in professional psychology (PsyD); licensed Stated interns with following credentials: MFT, LCSW; registered student interns with appropriate supervision or appropriate credentials identified by the agency. Only psychiatrists and psychiatric nurses can use items A-D, all other professions can record services B through D.

Substance Use services can be provided by personnel working under this Service Category who meet the criteria described in items as follows:

- Licensed or certified by the State of Nevada as a physician, registered nurse, practical nurse, clinical or counseling psychologist, psychological examiner, social worker, alcohol/drug abuse counselor, teacher, professional counselor, or marital and family therapist, or if there is no applicable licensure or certification by the state has a bachelor's degree or above in a behavioral science or human development related area and supervision by staff that has an appropriate credential; interns are appropriate personnel if they are supervised by a credentialed non-intern; OR
- Are qualified by education and/or experience for the specific duties of their position; (and)
- Are trained in alcohol or other drug specific information or skills. (Examples of types of training include, but are not limited to, alcohol or other drug specific in-services, workshops, substance abuse schools, academic coursework and internships, field placement, or residencies).

A physician must be employed or retained by written agreement to serve as medical consultant to the program.

All Mental Health/Substance Use staff is to be trained and knowledgeable about HIV/AIDS, the affected communities, and available resources. Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics, and implications as well as substance abuse, including cognitive impairment and generally accepted treatment modalities and practices.

Acupuncture services for Substance Use and Co-occurring disorder treatment must be performed by a licensed acupuncturist and in good standing of the Nevada State Board of Oriental Medicine.

References and further reading
All Part B funded providers should read their individual Part B contracts, as well as but not limited to, the Quality Management Plan and all local policies and guidelines set forth by the Part B office regarding the Part B program statewide. All referenced materials for standards are listed under the Universal Programmatic and Administrative National Monitoring Standards.

AETC National Resource Center for Mental Health for Persons Living with HIV
HIV/AIDS Bureau – National Monitoring Standards for Ryan White Part B Grantees: Program – Part B; April 2013.
HIV/AIDS Bureau – Policy Clarification Notice 16-02: Ryan White HIV/AIDS Program Services:

Eligible Individuals & Allowable Use of Funds, January 2016.
Las Vegas TGA – Ryan White Part A HIV/AIDS Program, Service Standards
Nevada Office of HIV/AIDS Policy Eligibility & Enrollment for Ryan White Part B, February 2016.
Ryan White HIV/AIDS Program Service Report Instruction Manual, September 2015.
US Substance Abuse and Mental Health Services Administration Products and Guidance for Individuals Living with HIV
US Department of Justice – Frequently Asked Questions Regarding Twelve-Step Recovery Programs

Nevada Medication Assistance Program (NMAP)

SERVICE CATEGORY DEFINITION

RWHAP, under HRSA, is the federal funding source for RWPB and the AIDS Drug Assistance Program, also known as the Nevada Medication Assistance Program (NMAP).

NMAP is a state-administered program authorized under RWPB to provide U.S. Food and Drug Administration (FDA) approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. RWHAP NMAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV. RWHAP NMAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. RWHAP NMAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. RWHAP NMAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

NMAP Services

Health Insurance to Provide Medication

Health Insurance to Provide Medications (HIP-Rx) is the provision of financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical and prescription benefits under a health insurance plan. This includes:

- Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low-income clients that provide a full range of HIV medications.
- Paying prescription drug co-pays and deductibles on behalf of the client.
- Providing funds to contribute to a client's Medicare Part D True Out-Of-Pocket (TrOOP) costs.

The Service Category for HIP-Rx is ADAP Insurance.

Funding allocated to NMAP provides an approved formulary of medications to People Living with HIV/AIDS (PLWH) for the treatment of HIV disease or the prevention of opportunistic infections.

CAREWare must be updated to indicate the type(s) of health insurance assistance service(s) that the client received during the reporting period.

Funded services include:

- *Insurance Enrollment* – Assisting clients with enrolling in insurance plans both private (Including but not limited to Private Individual, Open Enrollment Period, Qualifying Life Events, Private Employer, COBRA, etc) and public (Including, but not limited to Medicaid, Medicare, VA, etc.).
- Medicare Part D Co-Payment - Medicare Part D medication coinsurance or co-payment.
- Medicare Supplement Premium- Partial Payment (Part C/D) – Medicare Part C (Health Plan) or Medicare Part D (Drug Plan) partial premium payment where NMAP pays less than 100% of the premium cost, such as when the client receives a premium subsidy.
- Medicare Supplement Premiums- Full Payment (Part C/D) - Medicare Part C (Health Plan) or Medicare Part D (Drug Plan) full premium payment where NMAP pays 100% of the premium cost.
- Other Health Insurance Premium- Partial Payment – A health insurance plan, such as a private individual plan, a Marketplace plan, an employer plan, or a COBRA plan where NMAP pays a partial premium payment (i.e., such as when the client receives a premium subsidy through the Advance Premium Tax Credit)
- Other Health Insurance Premium- Full Payment - A health insurance plan, such as a private individual plan, a Marketplace plan, an employer plan, or a COBRA plan where NMAP pays the full premium payment.
- Other Health Insurance Co-Payment – A health insurance medication coinsurance or copayment.

Please note: Medicare Part A (solely) and Medicare Part B (solely) are not allowable to be funded individually per HRSA PCN 18-01. See table below for allowable funded parts.

Medicare Part	*RWHAP Funds*
Medicare Part A	Must not be used by any RWHAP recipient to pay premiums or cost sharing.
Medicare Part B	May be used by all RWHAP recipients to pay premiums and/or cost sharing in conjunction with paying for Medicare Part D premiums or cost sharing.
Medicare Part C	May be used by all RWHAP recipients to pay premiums and/or cost sharing when the Medicare Part C plan includes prescription drug coverage; or in conjunction with paying for Medicare Part D premiums and cost sharing for plans that do not include prescription drug coverage.
Medicare Part D Medicare Part D	May be used by RWHAP Part A, B, C, and D recipients to pay premiums or cost sharing in conjunction with paying Medicare Part B or Medicare Part C premiums or cost sharing. May be used by RWHAP ADAP recipients to pay Medicare Part D

(continued)	premiums and cost sharing when cost effective versus paying for the full cost of medications.

In NMAPs Domain of CAREWare, indicate the total amount ($0 to $100,000) of insurance premiums paid on behalf of the client during the reporting period in the Insurance Services Tab for premium payments and in the Drug Services Tab for medication coinsurance or copayments.

Note*: OoH uploads medication coinsurance and copayment data from the Ramsell Corporation Pharmacy Benefits Manager (PBM) for any medication that has been billed to NMAP. In rare circumstances where the Ramsell Corporation cannot be billed for medication coinsurance and co-payment, the information will need to be manually entered in NMAPs Domain of CAREWare on the Drug Services Tab and the NMAP Coordinator should be notified.*

Direct Medication Assistance Services
If an applicant is not eligible for a health insurance plan (a private individual plan, a Marketplace plan, an employer plan, or a COBRA plan) or public health insurance option (Medicare, Medicaid, Veteran Administration, Indian Health Service (IHS), etc.) then NMAP will cover the full cost of any medication that is on the NMAP Formulary.

CAREWare must be updated to indicate the type(s) of medication assistance service(s) that the client received during the reporting period.

Funded services include:

- NMAP Medication Assistance – A medication payment for an uninsured client
- Outpatient Ambulatory Health Services, CABENUVA ONLY – A medication and administration process for uninsured clients and clients whose individual plan does not cover CABENUVA.
- Outpatient Ambulatory Health Services, SUNLENCA ONLY – A medication and administration process for uninsured clients and clients whose individual plan does not cover SUNLENCA.

In NMAPs Domain of CAREWare, indicate the total amount ($0 to $100,000) of the medication payment paid on behalf of the client during the reporting period in the Drug Services Tab.

Note: *OoH uploads medication payment data from the PBM for any medication that has been billed to NMAP. In rare circumstances where the Ramsell Corporation cannot be billed for a payment, the information will need to be manually entered in NMAPs Domain of CAREWare on the Drug Services Tab.*

Service Delivery
NMAP Enrollment
Clients must first meet the requirements for Ryan White Universal Eligibility, i.e., POD, POR and POI Once it is determined that the client has a need for medication and/or health insurance assistance, then the NMAP referral process can begin. It is the responsibility of the

referring agency to ensure that all information is received, correct, and entered into CAREWare before sending the referral.

Additional review of the following is required to ensure clients eligible for NMAP services:

- Existing client insurance if any (Payor of Last Resort)

The originating agency will send a referral to NMAP (see Common Guidance Document for CAREWare instructions). NMAP subrecipient receiving the referral will have Fourteen (14) calendar days to review the referral for completion and either deny or accept the referral. If the referral is accepted, NMAP subrecipient must then place the client in the correct health insurance and/or medication assistance category and begin service delivery.

If it is determined that the client does not have up-to-date insurance documentation the NMAP subrecipient will have seven (7) business days (from receipt of a referral) to do the following:

- Reject the referral.
- Contact the referring agency that the referral has been rejected by email, phone call, or User Note
- The referring agency will then have two (2) business days to obtain the missing documentation and upload it into CAREWare.
- All attempts to contact the client must be documented in CAREWare Part B with detailed accounts of all attempts in the service notes.
- If the referring agency obtains the missing eligibility documentation, the documents must be uploaded into the CAREWare Part B Eligibility and Enrollment Fields tab.
- The referring agency will then create a new referral to the NMAP subrecipient.

Emergency Referrals:
The Emergency Referral is NOT an assistance category but a process for expedited assistance for new NMAP-eligible clients who have less than seven (7) days of medication. A client's insurance status should be established at this point to best determine the assistance to provide. If the client is pending insurance, they should be granted NMAP status until the end of their pending period. If a client has been determined to be ineligible for any kind of insurance, their coverage should be granted until the end of their RWPB eligibility.

The NMAP subrecipient must assess that they have a completed Ryan White Universal Eligibility application to approve NMAP services. Once the determination of a completed Universal Eligibility application is made, the NMAP subrecipient will have 48 hours (from receipt of a referral) to enroll the client in the correct health insurance or medication assistance category and begin service delivery.

If it is determined that the client does not have the necessary insurance verification documentation the NMAP subrecipient will have 48 hours (from receipt of a referral) to do the following:

- Reject the referral.
- Contact the referring agency that the referral has been rejected by email, phone call, or User Note.
- The referring agency will then have one (1) business day to obtain the missing documentation and upload it into CAREWare.
- All attempts to contact the client must be documented in CAREWare Part B with detailed accounts of all attempts in the service notes.
- If the referring agency obtains the missing eligibility documentation, the documents must be uploaded into the CAREWare Part B Eligibility and Enrollment Fields tab.
- The referring agency will then create a new referral to the NMAP subrecipient.

Other Missing Documentation
If the NMAP subrecipient finds that the client is missing other documentation for eligibility, they should first make a note of the URN and what is missing. Next, the NMAP subrecipient should send the information to the Office of HIV for further clarification. The NMAP subrecipient will not be held responsible for missing documentation beyond current insurance information.

NMAP Medication Assistance Categories
Within NMAP there are 12 internal NMAP medication assistance categories that a client may be enrolled into within the Ramsell Corporation, Pharmacy Benefit Management (PBM), System:

- *Medicare Part A/Part B combined (known as Original Medicare)*
- *Medicare Part C*
- *Medicare Part D*
- *Medicaid*
- *Private-Employer*
- *Private-Individual*
- *Military (VA, Tricare)*
- *Indian Health Services (IHS)*
- *Association Plan*
- *High Risk Insurance*
- *No Insurance*
- *Other (Only with NMAP staff approval)*

Clients approved for NMAP will receive a Ramsell Corporation Pharmacy Benefit card.

- Medication costs associated with the Ramsell Corporation medication assistance category of Medicare are considered Medicare Part D Co-Payments for PBM purposes.
- Medication costs associated with the Ramsell Corporation medication assistance categories of Individual Insured and Employer Sponsored Insurance are considered

the same Co-Payment categories for the PBM.
- Medication costs associated with the Ramsell Corporation Medication Assistance categories of Full Pay are considered No Insurance category for the PBM.

Insurance Enrollment
To be used when assisting a client with enrolling clients in any health insurance plan (a private individual plan, a Marketplace plan, an employer plan, or a COBRA plan) or public health insurance option (Medicare, Medicaid, VA, HIS, etc.)

Medicare
Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) are available to the individuals below:

- Age 65 or older and a U.S. citizen or lawfully admitted noncitizen who has lived in the
- U.S. for five continuous years; or
- Under age 65 and receiving Social Security Disability (SSDI) benefits or Railroad Retirement Board Disability benefits for at least 24 months from the date of entitlement; or
- Under age 65 and receiving Social Security Disability (SSDI) benefits or Railroad Retirement Board Disability benefits with Amyotrophic Lateral Sclerosis (known as ALS or Lou Gehrig's disease); or
- Any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Part D is the prescription drug benefit section of the Medicare Modernization Act of 2003. The Ramsell Corporation medication assistance category, Medicare, was implemented to work in conjunction with Part D. Part D would act as your primary insurance and NMAP would act as your secondary insurance to cover the remaining co-payment price.

Part D co-payments paid on the client's behalf by NMAP count towards the client's True Out-of-Pocket Cost (TrOOP). TrOOP costs count towards the Medicare beneficiary's out-of-pocket threshold which, once reached, will determine that the client begins catastrophic coverage. Catastrophic Coverage is when Part D pays 95% of the drug cost and the client pays the larger of either 5% of the drug cost or $2.95 (for generic) or $7.20 (for name brand). Clients at 150% FPL or below qualify for Low Income Subsidy (LIS) and are required to apply for the LIS assistance through the Social Security Administration.

It is the client's responsibility to maintain adherence to Part D and the Part D insurance provider's rules and regulations. Correspondence from Medicare or the health insurance plan is not sent to the NMAP Program; it is sent directly to the client.

Clients will select their Part D provider during open enrollment each year, in accordance with Medicare rules. This should be done as early in the open enrollment period as possible to allow time for processing through multiple agencies. Existing eligible clients will notify their

NMAP case manager, with proper documentation, of their provider choice. New clients will generally be enrolled into their Part D plan on the 1st of the following month. If the eligibility date is after the 15th of the month, the client will be eligible beginning the 1st of the month following the upcoming month. Exceptions can be made to enroll more quickly.

Note: NMAP requires all eligible clients to enroll in a Part D plan. NMAP strongly encourages Medicare clients to enroll in a Part C plan if eligible.

Private Individual
NMAP funding is the Payor of Last Resort for HIV medications. The program is responsible for providing HIV medications on the NMAP closed formulary to eligible clients in the most cost-effective delivery system. All clients and potential clients will be evaluated for inclusion in other programs before NMAP funding is used as payment for medications. The NMAP enrollment process will help to determine which NMAP service is the most cost-effective delivery system for the program.

HRSA guidelines permit each state to purchase health insurance for eligible NMAP clients for the sole purpose of providing medications. NMAP will, when fiscally suitable, assist clients with health insurance premiums and/or co-payments, depending on individual circumstances. NMAP is the Payor of Last Resort, therefore, a client's primary insurance i.e., Medicaid, Medicare, employer-sponsored insurance, spousal employer-sponsored insurance, COBRA, etc. must be billed first for covered medications and NMAP should be billed second to cover the medication co-payment.

NMAP may assist eligible clients with health insurance premium and medication co-payment assistance if the cost of paying the health insurance premium and medication co-payments are/is less than the cost to provide the client with direct medication assistance. Clients are required to disclose all insurance information during the Ryan White Universal Eligibility application process and present documentation when requested during the NMAP enrollment process (i.e., premium information, open enrollment timeframe, CORBA application, etc.). Clients will only have to submit proof of the monthly health insurance premium amount at their Universal Eligibility Annual and Recertification application appointments.

It is the responsibility of the client to report any change(s) that may occur within their six-month certification. It is the expectation of OoH that all changes are reported to the NMAP Program within 10 days of notification of that change; this includes but not limited to any increase or decrease in premium payments.

If client circumstances change and the client becomes eligible to enroll in health insurance through an employer, the Health Insurance Exchange, Medicare, Medicaid, etc., the client should present the health insurance information, enroll in the other insurance product, and report that change to the NMAP Program through a case manager within ten (10) days of notification of that change. Similarly, if health insurance status changes, the client should inform the case manager so that accurate premiums are paid by the NMAP Program. Failure

to produce the information in a timely manner may result in a lapse in health insurance premium payment, which would impact the client's health insurance enrollment and may cause the client to be suspended and/or discharged from NMAP.

Effective October 1, 2013, the State of Nevada implemented a Health Insurance Exchange in compliance with the Affordable Care Act (ACA). The web portal is called Nevada Health Link (NHL). All Nevadans are required to apply for marketplace insurance through nevadahealthlink.gov, if they do not have insurance through other means. Ryan White clients will be educated through NMAP case managers to help them decide the best health insurance plan that will cover their unique circumstances and medications. If a determination is made by Nevada Health Link that the client's income makes them eligible for insurance, then the NMAP Program must encourage enrollment in an approved insurance plan. The NMAP program has determined that it is cost effective to enroll clients into an insurance product versus paying the full cost of the medication(s).

All clients who are signed up for health insurance and receive an Advance Premium Tax Credit from the Internal Revenue Service (IRS) to assist with the affordability of monthly health insurance premium, will be required to provide all relevant tax information for the coverage year. The NMAP program will assist the client with the Advance Premium Tax Credit reconciliation process.

Qualified health insurance plans (QHP) sold on and off the Exchange/Marketplace are required to accept premium payments from the Ryan White associated providers under regulations of the Affordable Care Act. If there are any issues with an insurance company regarding health insurance premium payments, please contact the Nevada Office of HIV.

Note: Enrolled NMAP insured clients are required to utilize NMAP medication assistance for copays, co-insurance, and or deductibles.

Private Employer

To remain active and receive benefits all clients must maintain current Universal Eligibility enrollment through an annual certification and a recertification. Client also needs to provide current proof of insurance coverage through an employer. Proof can be in the form of an insurance card, a letter of coverage from the insurance company, a printout from the insurance company client portal, or an Employee Insurance Verification Form. In all cases the client's name and coverage dates must be present. Membership and Group number are preferred.

NMAP will, as program funds allow, assist clients with health insurance premiums and/or medication co-payments. Clients with credible and affordable employer-based coverage, that has been reviewed and approved by NMAP, may keep their current insurance, and may qualify for health insurance premium assistance. NMAP will also cover a client jointly insured through a spouse's employer-based coverage. When NMAP negotiates with an employer to accept health insurance premiums on behalf of a client, the company should be aware that the premium must be an after-tax item not a pre-tax item. Meaning, the client is not paying

the premium, so they do not qualify for pre-tax or tax-free deductions. Clients may opt-out of their employer sponsored insurance plans to opt-in to an On-Marketplace plan so long as they meet one of the following criteria:

- The employer sponsored insurance does not accept 3rd party payments,
- The employer sponsored insurance requires the use of mail order, and
- The employer sponsored insurance requires the use of a Specialty Pharmacy outside NMAPs closed Pharmacy Network.

Note: *Enrolled NMAP insured clients are required to utilize NMAP medication assistance for copays, co-insurance, and or deductibles.*

No Insurance
If an applicant is not eligible for a health insurance plan (a private individual plan, a Marketplace plan, an employer plan, or a COBRA plan) or public health insurance option (Medicare, Medicaid, VA, HIS, etc.) then NMAP will cover the full cost of any medication that is on the NMAP Formulary.

NMAP Formulary
The NMAP Formulary currently has 43 Antiretroviral Medications (ARVs) and over 100 other related medications. The Formulary is updated with input from the Food and Drug Administration (FDA), National Alliance of State & Territorial AIDS Directors (NASTAD), and the Silver States Script Board (SSSB). Guidance from the SSSB started July 1, 2022. Information pertaining to SSSB can be located here.

Emergency Referral
The Emergency Referral is NOT an assistance category but a process for expedited assistance for new NMAP-eligible clients who have less than seven (7) days of medication. A client's insurance status should be established at this point to best determine the assistance to provide. If the client is pending insurance, they should be granted NMAP status until the end of their pending period. If a client has been determined to be ineligible for any kind of insurance, their coverage should be granted until the end of their RWPB eligibility.

Continued Enrollment
To remain active and receive Ryan White or NMAP Program benefits, all clients must maintain Universal Ryan White Eligibility to avoid a lapse of benefits. Case managers will contact OoH staff if a client has unique circumstances or if there is any doubt that the client qualifies for the NMAP Program. The client should be told that they will be contacted once the questions have been clarified. Case managers must notify AHN, via referral, regarding any NMAP Program client that has become disqualified from health insurance before they cease paying insurance premiums, this includes noncompliance for recertification.

Open Enrollment (November 1 – January 15):
Clients are strongly encouraged not to enroll in an Affordable Care Act (ACA) Marketplace health insurance plan on their own and not to allow the ACA Marketplace to automatically re-enroll them. Clients who enroll on their own or allow the ACA Marketplace to automatically re-enroll them may inadvertently choose a plan that is not cost-effective does not sufficiently cover their needs or does not meet the NMAP program guidelines or limitations for assistance. Furthermore, NMAP clients who enroll on their own in the ACA Marketplace may lose all access to NMAP assistance with NMAP prescription drugs, ACA premiums, and ACA drug copayments; and may lose access to Wraparound assistance with allowable copayments and deductibles from the Ryan White Part B Program.

Financial Reimbursement
Reimbursement to clients is strictly prohibited by HRSA for any expenses.

Medicaid
In 2012, Nevada Governor Brian Sandoval announced that under the ACA Nevada would expand Medicaid to cover incomes up to 138% FPL, in most cases although some exceptions apply. Ryan White clients are encouraged to apply for Medicaid if they meet the eligibility requirements. If the client is ineligible for Medicaid, then the case manager will determine if the client meets the eligibility requirements for health insurance through another source.

Clients whose income is at or below 138% FPL, and meet residency requirements, must be assisted with a referral to Medicaid for eligibility determination. If a client's income makes them eligible for Medicaid, eligible clients must participate in Medicaid. If a client refuses a referral to Medicaid, the client should be made aware that this could disqualify them from receiving NMAP services. Medication services can be approved on a case-by-case basis by the Office of HIV. Any coverage must be approved by the OoH before it can go into effect.

Bridge Coverage

Clients that have provided proof of a Medicaid application, employer insurance start date verification, or open enrollment start date but have not been authorized for benefits, may receive NMAP services as a "bridge" between coverage and NMAP Program benefits. The "bridge" will be from the application date until the stated start date on received documentation.

Medicaid active clients are not eligible to receive NMAP services.

Pharmacy Assistance Program
The Pharmacy Assistance Program or Patient Assistance Program (PAP) is provided by drug manufacturers. If a client cannot obtain medications through the NMAP Program, the client may be referred to a PAP program. The PAP may assist clients with medications at no charge or for a cost-share. NMAP does not allow the use of the PAP for drug(s) on the NMAP formulary.

Pharmacy Agreements
Effective July 1, 2025, Ramsell Corporation Medicaid Administration became NMAP's Pharmacy Benefit Manager (PBM). Clients deemed eligible for NMAP will be entered into the PBM system by the NMAP provider. Pharmacists will not be able to fill medication prescriptions for clients who have not met Universal Ryan White Eligibility and who have been activated in the Ramsell Corporation PBM system.

Insurance Pharmacy Network
Clients must access medications assistance through the NMAP's approved expanded pharmacy network administered by NMAP's PBM. If a client has chosen to use an out-of-network pharmacy, they are choosing to opt-out of enrollment and services in NMAP. Opting out of NMAP means the program will no longer be able to pay for the client's insurance premiums and/or the costs of medications and the client will be responsible for the full cost of their medications and/or insurance premiums.

Outpatient Ambulatory Health Services – CABENUVA AND SUNLENCA

SERVICE CATEGORY DEFINITION

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

Cabenuva – co-packaged cabotegravir and rilpivirine extended-release injectable suspensions – was approved by the U.S. Food and Drug Administration on January 21, 2021. Cabenuva is indicated as a complete regimen for the treatment of HIV-1 infection in adults to replace the current antiretroviral regimen in those who are virologically suppressed on a stable antiretroviral regimen, with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine. Cabenuva is an extended-release antiretroviral gluteal intramuscular injectable that requires administration by a licensed healthcare professional in a licensed healthcare setting.

On October 1, 2022, Cabenuva was added to the NMAP formulary. Due to the unique administration process Cabenuva requires, NMAP has funded Community Outreach Medical Center (COMC), through a pilot project, to be the administration site for uninsured clients as well as NMAP clients whose' s insurance do not cover Cabenuva. This pilot project is only for southern Nevada clients currently.

Sunlenca (lenacapavir)- was approved by the U.S. Food and Drug Administration (FDA) on December 22, 2022, for people living with HIV/AIDS (PLWHA) whose HIV infections cannot be successfully treated with other available antiretrovirals due to resistance, intolerance, or safety considerations.

On November 20,2023, Sunlenca was added to the NMAP formulary. Due to the unique administration process Sunlenca requires, NMAP has funded Community Outreach Medical

Center (COMC), to be the administration site for uninsured clients as well as NMAP clients whose' insurance does not cover Sunlenca. This is only for southern Nevada clients currently.

Note: *For northern Nevada Clients, only Northern Nevada HOPES established patients can seek assistance for access to Cabenuva at this time. As of now, only patients who are on either Nevada Medicaid, Medicare with Part D plan or on a private commercial insurance are being offered Cabenuva through Northern Nevada HOPES.*

Currently Funded Services:

A. Office Visit
B. Laboratory/Diagnostic Service
C. Medication Therapy Management
D. Administration
E. Injection

Service Delivery

Clinical Considerations for Cabenuva

- Prior to initiating Cabenuva as maintenance therapy, patients will need to be virally suppressed on a stable oral regimen, with no known or suspected resistance to either cabotegravir (an integrase strand transfer inhibitor) or rilpivirine (a non-nucleoside reverse transcriptase inhibitor).
- Oral lead-in dosing with Vocabria (30 mg cabotegravir) and Edurant (25 mg rilpivirine) used for one month to assess the tolerability of cabotegravir and rilpivirine *is now optional*. Thirty-day supplies of Vocabria and Edurant will be provided by ViiV Healthcare through a non-commercial dispensing pharmacy without cost to the patient, provider, or payer (including NMAP); Vocabria will not be available from community/retail pharmacies.
- Cabenuva initiation dosing requires two 3 mL IM injections (600 mg cabotegravir plus 900 mg rilpivirine), administered at separate gluteal injection sites during the same visit.
- Cabenuva continuation dosing involves either of the following:
    - Two 3 mL gluteal IM injections (600 mg cabotegravir plus 900 mg rilpivirine) administered every two months; *or*
    - Two 2 mL gluteal IM injections (400 mg cabotegravir plus 600 mg rilpivirine) administered every month.
- Continuation injections should be initiated a month after the initiation injections. There is a 14-day window for receiving injections – either 7 days before or 7 days after the target treatment date.
- If injections are planned to be missed or delayed by more than seven days, clients should discuss with their health care providers oral "bridging" therapy – e.g., oral therapy of one Vocabria tablet (to be requested via ViiVConnect) plus one Edurant tablet until the next injection can be administered – until injections can be restarted.

Office Visit (Item A)

A medical office visit is with a licensed medical healthcare provider. Services provided during the office visit can include any of the following: medication treatment adherence counseling

and education; prescription and management of medication therapy; provision of laboratory diagnostic slip; diagnostic referral; preventive care screening; risk assessment; and laboratory or diagnostic results counseling.

Laboratory/Diagnostic Service (Item B)
All clients living with HIV receiving medical care must receive frequent-to-periodic laboratory testing. The Nevada Office of HIV/AIDS supports the most recently revised "Guide for HIV/AIDS Clinical Care." Laboratory & Diagnostic Services are any of the approved specimen testing that is related to the client's HIV medical care. Non-routine laboratory and diagnostic services will need a citation of the Guideline's page number where that clinical recommendation is made.

Medication Therapy Management (Item C)
Pharmacists work collaboratively with physicians and other health care professionals to optimize the medication use by a patient consumer. Consultative services can either be with the patient consumer or with the health care team and are meant to be patient centered rather than product centered. Medication management services should be informed by the American Pharmacists Association's publication, Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model.

Treatment Adherence Counseling Consultation (OAHS) [Item D]
Administration is the first initial intermuscular injection of Cabenuva that a client receives. This is the beginning process of Cabenuva.
Injection(s) [Item E]
Injection(s) are all other Cabenuva injections following the Administration. It is important to note in the service notes what number of injection the client is on.

INSTRUCTIONS
Uninsured Clients:
All southern Nevada uninsured clients considered full-pay through NMAP, are required to be referred to COMC for administration of Cabenuva.

External Referrals: The COMC external referral form is required to be completed by the referring primary care physician (PCP) to start the process of Cabenuva. Once the completed form is returned to COMC, COMC will follow their Standard Operating Procedure (SOP) Cabenuva Program-External Referral, to allow the client access to Cabenuva.

Internal Referrals: If the client is already a patient at COMC, the SOP Cabenuva Program-Internal Referral process should be followed to allow the client access to Cabenuva.

Insured Clients:
All southern Nevada insured clients whose insurance does not cover Cabenuva are required to be referred to COMC for administration of Cabenuva.

External Referrals: The COMC external referral form will need to be completed by the referring PCP to start the process of Cabenuva. Once the completed form is returned to

COMC, COMC will follow their Standard Operating Procedure (SOP) Cabenuva Program-External Referral, to allow the client access to Cabenuva.

Internal Referrals: If the client is already a patient at COMC, the SOP Cabenuva Program-Internal Referral process should be followed to allow client access to Cabenuva.

Personnel Qualifications (including licensure)
Administration of Cabenuva is to be provided by a licensed healthcare provider in an outpatient medical setting for HIV-related visits. Services are to be consistent with HHS Clinical Guidelines for the Treatment of HIV.

Diagnostic and laboratory tests are:

- Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider.
- Consistent with medical and laboratory standards.
- Approved by the FDA and/or certified under the Clinical Laboratory Improvement Amendments (CLIA) Program.

- This section left blank -

Community Outreach MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

REFERRAL FOR COMC SERVICES

P: (702) 657-3873 - F: (702) 636.0787
Secure Email: referral@nvcomc.org
1090 E. Desert Inn Road – Las Vegas, NV 89109

Date: _____

Submit completed referral form through CAREWare A or B or via Secure Email

REASON FOR REFERRAL (Please check all that apply)

PHYSICAL HEALTH SERVICES:	ADDITIONAL SERVICES:
☐ Primary Care/ General Medicine ☐ PrEP & PEP ☐ CABENUVA ☐ SUNLENCA	☐ Ryan White Services ☐ Community Resources ☐ Other _____

Referring Agency: _____ Referred by: _____

Phone number: (____) _____ Email: _____

Referring Provider: _____ Provider Signature: _____

CLIENT INFORMATION

Client Name: _____ Preferred Name: _____

DOB (mm/dd/yyyy): _____ Age: _____ SSN# _____-_____-_____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ May we leave a message ☐ Yes ☐ No

Permission to call: ☐ Yes ☐ No Best Time to call: _____

Email: _____ Okay to Email? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Sex at Birth: ☐ Male ☐ Female Gender Identity: ☐ Male☐ Female ☐ MTF ☐ FTM ☐ Other: _____

Race: ☐ Black/African American ☐ White/Caucasian ☐ American Indian/ Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Other_____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown

Health insurance

Insurance Information: _____

Member ID#: _____ Group #: _____

Primary Care Physician: _____

HIV Specialist Provider: _____

ADDITIONAL NOTES/INSTRUCTIONS: **Attach supporting documents such as Labs to include Viral Load and CD4 Count; Last Progress Notes: include history of medication adherence and resistance, Proof of Diagnosis, Known Allergies, etc.**

Outpatient Ambulatory Health Services – except CABENUVA & SUNLENCA

SERVICE CATEGORY DEFINITION

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

Currently Funded Services:

A. Office Visit
B. Laboratory/Diagnostic Service
C. Medication Therapy Management

Office Visit (Item A)
A medical office visit is with a licensed medical healthcare provider. Services provided during the office visit can include any of the following: medication treatment adherence counseling and education; prescription and management of medication therapy; provision of laboratory diagnostic slip; diagnostic referral; preventive care screening; risk assessment; and laboratory or diagnostic results counseling.

Laboratory/Diagnostic Service (Item B)
All clients living with HIV receiving medical care must receive frequent-to-periodic laboratory testing. The Nevada Office of HIV/AIDS supports the most recently revised "Guide for HIV/AIDS Clinical Care." Laboratory & Diagnostic Services are any of the approved specimen testing that is related to the client's HIV medical care. Non-routine laboratory and diagnostic services will need a citation of the Guideline's page number where that clinical recommendation is made.

Diagnostic and laboratory tests are:

- Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider.
- Consistent with medical and laboratory standards.
- Approved by the FDA and/or certified under the Clinical Laboratory Improvement Amendments (CLIA) Program.

Medication Therapy Management (Item C)
Pharmacists work collaboratively with physicians and other health care professionals to optimize the medication use by a patient consumer. Consultative services can either be with the patient consumer or with the health care team and are meant to be patient centered rather than product centered. Medication management services should be informed by the American Pharmacists Association's publication, Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model.

Subrecipient Responsibilities:

A. Ensure client medical records document services provided with dates and frequency of services provided included
B. Include clinical notes signed by licensed provider in client records
C. Make all certificates and licensures available upon request
D. Document the number of diagnostic and laboratory tests performed, the certificates, licenses, or FDA approval of the laboratory from which tests were ordered, and the credentials of those ordering the tests

Personnel Qualifications (including licensure)
All outpatient services are to be provided by a licensed healthcare provider in an outpatient medical setting for HIV-related visits. Services are to be consistent with HHS Clinical Guidelines for the Treatment of HIV.

SECTION III: SUPPORT SERVICES

- This page intentionally left blank

Emergency Financial Assistance (EFA) (Not currently funded)

SERVICE CATEGORY DEFINITION:

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

Emergency Financial Assistance

- To provide financial assistance to a client that needs emergency financial assistance for essential services including utilities, housing, food, or medications.
- To provide financial assistance to a new client that needs emergency financial assistance for essential services including utilities, housing, food, or medications.

PROGRAM GUIDANCE:

Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

ELIGIBLE SERVICES AND COSTS:

Clients must present the appropriate documentation that qualifies as an emergency:

- Unexpected event that hinders ability to meet housing, utility, food, or medication need; and/or
- Unexpected loss of income; and/or
- Experiencing crisis situation that hinders ability to meet housing, utility, food or medication need.

Essential Utilities:

The client must present bill notice and exhibit the inability to pay the bill due to an emergency as described above to receive Emergency Financial Assistance. Additionally, to be eligible, the person or a member of the resident household must present evidence that he/she is named on the essential utility bill. An eligible client may receive a maximum of five (5) EFA issuances – Essential Utilities assistance with a cap of $1,500 per grant year from any Part A funded agency. Assistance is subject to the availability of funding.

Eligible services are defined as:

- One EFA – Utility Assistance related visit

Prior to submitting a referral for EFA for Essential Utilities, the referring provider shall assist the client in seeking at least two (2) alternate funding sources, outside of the Ryan White continuum of care. If the referring provider is unable to secure alternate funding, they will be required to provide documentation of their efforts, including the reason(s) each alternate

funding source was unable to assist the client.

Essential Housing:
The client must present bill notice and exhibit the inability to pay the bill due to an emergency as described above to receive Emergency Financial Assistance. Additionally, to be eligible, the person or a member of the resident household must present evidence that he/she is named on the lease agreement or mortgage. An eligible client may receive a maximum of three (3) EFA issuances – Essential Housing assistance with a cap of $3,000 per grant year from any Part A funded agency. Assistance is subject to the availability of funding.

Eligible services are defined as:

- One EFA – Housing Assistance related visit

Prior to submitting a referral for EFA for Essential Housing, the referring provider shall assist the client in seeking at least two (2) alternate funding sources, outside of the Ryan White continuum of care. If the referring provider is unable to secure alternate funding, they will be required to provide documentation of their efforts, including the reason(s) each alternate funding source was unable to assist the client.

Essential Groceries, Food Vouchers and Food Stamps:
Client must present with an emergency as described above to receive Emergency Financial Assistance. An eligible client may receive essential groceries, food vouchers and/or food stamps. Assistance is subject to the availability of funding.

Eligible services are defined as:

- One EFA – Food Assistance related visit

Essential Medication:
Client must present a Physician's prescription (including over the counter medication) or bill notice for corrective prescription eye wear and exhibit the inability to pay the bill due to an emergency as described above in order to receive Emergency Financial Assistance. Funds may also be utilized by Outpatient/Ambulatory Medical Care funded providers to purchase medications needed on an emergency basis. Assistance is subject to the availability of funding.

Eligible services are defined as:

- One EFA – Medication Assistance related visit

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. A decrease in fees must also be reported so that expansion to serve more clients can be reviewed and implemented if applicable.
All approved applications should be paid on the client's behalf within ten business days and no payments will be made directly to a client for any reason.

INELIGIBLE SERVICES AND COSTS:
Funds awarded under the Ryan White HIV/AIDS Program may NOT be used for:

- Direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees and;
- The purchase of clothing and;
- Payment of local or State personal property taxes, including residential property, private automobiles, or any other person property against which taxes may be levied.

Health Education/Risk Reduction

SERVICE CATEGORY DEFINITION

Health education and risk reduction activities educate clients living with HIV about how HIV is transmitted and how to reduce the risk of transmission. Topics covered may include:

- Counseling to help clients living with HIV improve their health status and reduction of risk to others.
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage).
- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention.
- Health literacy.
- Information about medical and psychosocial support services.
- Treatment adherence education and reengagement of people who know their status but who are out of care into Outpatient/Ambulatory Health Services.

Program Guidance: Health Education/Risk Reduction services cannot be delivered anonymously.

OoH recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Recipient Office and we will provide the necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on clients.

Currently Funded Health Education and Risk Reduction Services:

A. Health Education Session (Group)
B. Health Education Counseling (Individual)
C. Chronic Disease Self-Management Program
D. Positive Self-Management Program Session

Service Delivery
Health Education Sessions (Item A)
Health Education Sessions must be designed to include any of the following components: (1)

Counseling to help clients living with HIV improve their health status and reduction of risk to others; (2) Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage); (3) Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention; (4) Health literacy; (5) Information about medical and psychosocial support services; or (6) Treatment adherence education. If an agency is unsure that their topic may not be allowable, please contact the Care Services Specialist for the Ryan White Part B Program.

Health Education Counseling (Item B)
Health Education Individual Counseling will assist in the: (1) development of a client individualized health education or self-management improvement plan, in collaboration with the client that addresses and increases the client's capacity in the curriculum's components; (2) tracking of client's progress using assessment tools; and (3) adjustment in the improvement plan, as necessary.

Chronic Disease Self-Management Program (Item C) or Positive Self-Management Program (Item D)
This six-week chronic disease self-management program teaches techniques to deal with frustration, fatigue, pain and isolation, exercise strategies, healthy eating, among other topics. The PSMP Workshop is a highly interactive mutual support and success builds the confidence you need to manage your health and health care and maintain an active and fulfilling life living with HIV.
The PSMP Workshop covers:

- Techniques to deal with problems such as frustration, fatigue, pain and isolation.
- Appropriate exercises for maintaining and improving strength, flexibility and endurance.
- Appropriate use of medications
- Communicating effectively with family, friends, and health care professionals
- Techniques for healthy eating
- How to make an action plan
- Learning problem-solving and decision-making skills

Staff will complete a standardized contact and short assessment with all clients to determine readiness and need for services, considering the following factors: (1) barriers to enrollment in RWPB and adherence to medications and medical care; (2) history of adherence, treatment, and opportunistic infections; and (3) the sufficiency of self-management and to provide referrals, when appropriate, to prevent lapses in care.

Personnel Qualification (Including licensure)
The minimum educational experience for service items A through E shall be:

- a B.A. or B.S. degree in any of the following disciplines: psychology, social work, counseling, sociology, community health, nursing, and public health; or,
- an associate degree in any of the fields above with two years of experience working in a job related to public health, outreach work, community services, supportive work

with children, families, or a different targeted population; or,
- Four years of experience working in a job related to public health.

If qualified individuals do not have HIV related work experience, they must receive HIV specific training within six months of hire.

Housing Services

SERVICE CATEGORY DEFINITION

Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:

- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support services but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

RWHAP recipients and subrecipients must have mechanisms in place to allow newly identified clients access to housing services. RWHAP recipients and subrecipients must assess every client's housing needs at least annually to determine the need for new or additional services. In addition, RWHAP recipients and subrecipients must develop an individualized housing plan for each client receiving housing services and update it annually. RWHAP recipients and subrecipients must provide HAB with a copy of the individualized written housing plan upon request.

RWHAP Part A, B, C, and D recipients, subrecipients, and local decision-making planning bodies are strongly encouraged to institute duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients and subrecipients consider using HUD's definition as their standard.

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

Housing Assistance Services

A. Initial Assessment/Development (Housing)
B. Reassessment/Redevelopment
C. Rent Assistance
D. Housing Attainment Fees
E. Rent Gap

Service Delivery

Initial Assessment/Development (Housing) [Item A] and/or Reassessment/Redevelopment (Housing) [Item B]

Clients receiving Housing assistance must have a Housing Plan documented in the client chart. It should, at a minimum, include the following:

- Identified issues
- Goal/objective
- Service provided
- Monthly and total cost
- Service start date
- Check amount
- Date the check was mailed
- Recipient of check
- Signature of client and case manager

The client's Housing Plan also includes a personal budget that will be created and revisited at each assessment period. If a client is receiving rental assistance through the HOPWA program, and they are eligible for services through a local Housing Authority, or other community housing resources; they are asked to apply for and provide documentation of applying within 30-days after initially receiving HOPWA funding. The client is required to provide the following documentation: proof of rent/mortgage, income, and expenses. This can include bank statements, payroll stubs, bills, letter from employer, etc. Proof of all income and expenses will be requested. This includes a lease or rental agreement and a W-9 for the person being paid rental assistance.

The periodic review and revision of the Housing Plan must be completed no less than twice within a benefits year.

Rent Assistance [Item C]

Short-term housing payments must be carefully monitored by the provider to assure limited amounts, limited use, and for limited periods of time. In addition, funds received under the Ryan White HIV/AIDS Program must be used to supplement, but not supplant funds currently being used from local, state, and federal agency programs. Ryan White HIV/AIDS Program Grantees must be capable of providing HAB with documentation related to the use of funds as the Payor of Last Resort and the coordination of such funds with other local, state, and federal funds.

Prior to receiving Housing assistance, the provider shall assist the client in seeking at least two (if in Clark County) or one (if elsewhere in Nevada) alternate funding sources in the community.

This program is meant for short-term assistance needed due to financial hardship. An individual may not have more than 24 lifetime months of rental assistance starting October 1, 2017. Rent Assistance may be provided up to $100 over the HUD Fair Market Rent for the county in which the consumer is living. It is the program's preference that options for Efficiency Rooms are found before One-Bedroom units for individuals.

Housing Attainment Fees [Item D]
Housing Attainment Fees are application fees, background check fees, and non-refundable move-in fees are fees that must be paid by the tenant before they are allowed to move in. Only non-refundable fees can be covered by the Ryan White HIV/AIDS Program. Rental Deposits are not allowable per HRSA-HAB Housing Services Frequently Asked Questions for Policy Clarification Notice 16-02.

Rent Gap [Item E]
An emergency rental gap is created when there is a difference between the full rent amount and the subsidized rental assistance. When a consumer is receiving housing assistance through another program and has a cost-sharing portion but if the consumer is unable to pay their cost-share then EFA Rental Gap may be used. This service can only be used once within a grant year by the consumer. If the consumer needs EFA Rent Gap assistance for more than one month, then the case manager will review less expensive rental units with the client.

References and further reading
HIV/AIDS Bureau – Policy Clarification Notice: 16-02: Housing Services Frequently Asked Questions for Policy Clarification Notice 16-02
Nevada Office of HIV/AIDS Policy Eligibility & Enrollment for Ryan White Part B
Ryan White HIV/AIDS Program Service Report Instruction Manual, June 25, 2021 X.

Medical Transportation

SERVICE CATEGORY DEFINITION

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

Program Guidance: Medical transportation may be provided through:

- Contracts with providers of transportation services.
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal programs (Federal Joint Travel Regulations provide further guidance on this subject);
- Purchase or lease of organizational vehicles for client transportation programs, *provided the recipient receives prior approval for the purchase of a vehicle from the*

Recipient Office.

- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); and
- Voucher or token systems.

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

Special Note: Continued provision of this service is limited to bus, train, ridesharing, taxi (emergency only), etc. and no longer includes use of agency vehicles. Under this service category, funding will only be for northern Nevada agencies.
Unallowable costs include:

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

OoH recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Recipient Office, which will provide necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on clients.

Currently Funded Medical Transportation Services

A. Taxi Voucher
B. Fuel Voucher
C. Bus Pass
D. Ridesharing
E. Transportation Scheduling
F. Rural Transportation

Service Delivery
Taxi Voucher [Item A]
Taxi vouchers are available to clients for the purpose of seeking emergency medical and/or psychiatric care only. Exceptions can be approved by the subrecipient with proper documentation in the client's case file. In CAREWare, each taxi voucher is one service unit.

Fuel Voucher [Item B]
Fuel vouchers will be primarily used for clients who have access to a vehicle for transportation to and from medical or support services. Subrecipients providing fuel vouchers must have a mechanism in place for tracking the utilization of this service for HIV related medical or support services. In CAREWare, each fuel voucher is one services unit.

Bus Pass [Item C]
Bus passes are the appropriate method of transportation to be provided for clients who live inside the service area of the Regional Transportation Commission. Each agency providing this service must have a mechanism in place for tracking the utilization of bus passes for HIV-related medical or support services. In CAREWare, each bus pass is one service unit.

Ridesharing [Item D]
Usage of Transportation Network Companies (such as Lyft or Uber) will be provided as a means for clients to have access to medical or support services related to their HIV status. Subrecipients providing funding for ridesharing must have a mechanism in place for tracking the utilization of this service for HIV-related medical or support service. In CAREWare, each ridesharing ride, one-way, is one service unit.

Transportation Scheduling [Item E]
Transportation scheduling may be utilized by the subrecipient to document staff effort to schedule clients' transportation needs, such as ridesharing scheduling. There must be direct contact with clients to be considered transportation scheduling and not an administrative expense.

Rural Transportation [Item F]
For situations in which a client is not covered by urban rideshare/RTC transportation options, subrecipients may provide funding for other options in rural counties such as Amtrak/Private Bus Companies. This is defined as any client that needs to travel more than 100 miles round trip in order to get to their treatment. Subrecipient providing transportation via train or commercial bus must have a mechanism in place for tracking the utilization of this service for HIV related medical or support services. In CAREWare, each ride, one-way, is one service unit.

Process
The Service Standard provides a step-by-step process for conducting medical transportation services activities. The process steps below provide additional information in implementing these roles.

A. The subrecipient must ensure that medical transportation services are provided in the most cost-effective manner possible to meet the needs of multiple clients. Therefore, in areas where public transportation is available, a bus pass (one-way or two-way) is the first choice for clients accessing Ryan White Transportation.

B. Appropriate utilization for medical transportation services - Subrecipient will consider poverty, capacity, stigma, and health disparity related barriers to transportation and attempt resolution through provision of medical transportation assistance or other available resources prior to providing medical transportation services. Subrecipients will verify linkage of PLWH to HIV care and treatment services. Medical transportation services include, but are not limited to, the following types of appointments:
    - Doctor appointments.
    - Medical case management appointments.
    - Mental health and substance abuse treatment appointments.

- HIV-related support groups.
- Dental appointments.
- Lab work.
- Pharmacy visits.
- Ryan White funded medical and support services; and
- Other support and medical services deemed necessary to aid a client to obtain medical or support care, stay in medical or support care, remain adherent to treatment, or achieve expected health outcomes.

C. All funded medical transportation subrecipients are required to maintain a method to track all requested transportation services and ensure that all of the trips were taken and were appropriately used to access HIV related services. The subrecipient will maintain a master transportation tracking log; clients do not need to maintain individual transportation tracking logs. Proper documentation must be obtained and tracked for all clients and services. Documentation must contain the following information:
   - Name of client.
   - Date of request for transportation service.
   - Date of appointment.
   - Trip origin and destination (such as the name and address of the medical provider);
   - Each trip starting and ending mileage (for fuel vouchers);
   - Number of Units Provided.
   - Cost Per Unit; and
   - Signature of person receiving service (to indicate the client receive their fuel voucher reimbursement, bus pass, or taxi voucher). (Rideshare reimbursed by the subrecipient will be initialed by non-medical case manager)

D. Fuel Voucher(s): Subrecipient providing medical transportation must adhere to the following:
   - Fuel voucher amounts will depend on the location and distance of the appointment from the client's primary residence.
   - Fuel vouchers are given to HIV positive clients who live at least 20 miles away, roundtrip, from their service provider to help offset the cost of traveling to their medical or support services appointments.
   - When finances permit, clients who live closer than 20 miles roundtrip, and whom are in financial need, may receive a fuel voucher reimbursement.
   - *Times when an exception is permitted will be designated by the subrecipient agency and documented that an exception was made in the client's case file.*

E. Taxi Voucher: Subrecipient must ensure that clients who receive taxicab vouchers through medical transportation services have a medical emergency, physical and/or cognitive limitations, or severely inclement weather which prohibits the use of other transportation sources and/ or have no available public transportation or other resource.

F. Ride Sharing: Subrecipient providing medical transportation must adhere to the following:
   - Subrecipient agencies may use Ride Sharing only when no other means of transportation is available or appropriate.
   - Ride Share services must be pre-approved by the subrecipient agency at a minimum with 48 hours' notice.
   - Ride Share reimbursement cannot exceed the federal mileage reimbursement rate.
   - Billed mileage may not exceed documented mileage.
   - Clients must provide evidence of attendance to their Core and/or Support services prior to reimbursement. Trip documentation must include addresses to and from named destination points, and mileage.

G. Medical Transportation must be reported as a Support Service in all cases, regardless of whether the client is transported to a Core or Support service.

H. Ryan White is the Payor of Last Resort and should only be used when a client in need of transportation assistance is not eligible for this service through any other funding source.

Personnel Qualifications (including licensure)
Suggested minimum High School Diploma, college graduate preferred. Staff should have HIV-related experience. If qualified individuals do not have HIV related experience, they must receive HIV specific training within six (6) months of hire.

Non-Medical Case Management

SERVICE CATEGORY DEFINITION

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

- Initial assessment of service needs.
- Development of a comprehensive, individualized care plan.
- Encourage clients to get annual CD4 and Viral Load labs.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.

- Continuous client monitoring to assess the efficacy of the care plan.
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary.
- Ongoing assessment of the client's and other key family members' needs and personal support systems.

NMCM Services have as their objective providing coordination, guidance, and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health case outcomes.

The State of Nevada recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Recipient Office and we will provide the necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects for clients.

Currently Funded Non-Medical Case Management Services

A. Initial Assessment/Development (NMCM)
B. Reassessment/Redevelopment (NMCM)
C. Referral & Related Activities (NMCM)
D. General Monitoring (NMCM)
E. Discharge Planning for NMCM

Service Delivery

Initial Assessment/Development (NMCM) [Item A]

An initial assessment must be developed when a non-medical case management agency does not perform eligibility activities, and therefore cannot use the Universal Eligibility Application in lieu of a comprehensive non-medical case management plan. Initial Assessment/Development should be used when the non-medical case manager and client have created an individualized non-medical case management care plan and it has been uploaded into CAREWare.

Individualized Care Plans: An Individualized care plan provides the basis from which the non-medical case manager and client work together through an interactive process, where problems are identified, prioritized, and are addressed through a planning process the includes the development of goals, assigned activities, and reporting of outcomes.

- The individualized care plan should be updated every six months to evaluate the effectiveness and relevance of the plan, measuring the clients progress toward meeting stated goals and activities, and to revise the plan as needed.
- Follow-up and monitoring activities can occur through direct contact (i.e., face-to-face meeting, telephone communication, texting, email, instance messing) with the client.

Reassessment/Redevelopment (NMCM) [Item B]

A comprehensive reassessment of the individual's needs must be developed when a non-medical case management agency does not perform eligibility activities, and therefore

cannot use the Universal Eligibility Application in lieu of a comprehensive non-medical case management plan. A reassessment should be done every six months after the previous assessment. Reassessment/Redevelopment should be used when the non-medical case manager and client have created a reassessment of the individualized non-medical case management care plan, and it has been uploaded into CAREWare.

CD4/Viral Load Labs:

- CD4 and Viral Load labs are important monitoring tools to show how the client is progressing in their treatment. They also required documentation for the Ryan White HIV/AIDS Program Services Report, or RSR, filled out by subrecipients each year. Case managers should either work with the clients to get them into yearly testing at a health district that reports findings or get tested and bring in the results for the case manager to upload into CAREWare.

Referral and Related Activities (NMCM) [Item C]

Referral and Related Activities should be used to help the eligible individual obtain needed services through referrals internal and external to CAREWare, including activities that help link the individual with medical, social, and support providers or other programs and services that can provide needed services to address identified needs. Referral and related activities should also be used when non-medical case managers follow-up on a referral made to another provider to ensure completion or rejection of a referral, or when following-up with a client to ensure the client's needs have been met.

Referrals: After each initiated referral, non-medical case managers must conduct a 30-day follow-up on a referral made to another provider to ensure completion or rejection of a referral, or when following-up with a client to ensure the client's needs have been met. *Internal Referrals* should be closed out in CAREWare by the receiving agency, *External Referrals* should be closed out by the initiating agency.

General Monitoring (NMCM) [Item D]

General Monitoring should be used when a non-medical case manager engages in interactions with a client to assess the client's service needs and satisfaction; this can be done through telephone, face-to-face contacts, emails, etc. This can be collaboration with the client, family or caregiver, or providers of services. The case manager should be in contact regularly with the client to be aware of any changes in the client's service needs or life events. General Monitoring should be non-eligibility-based interactions and contacts.

General Monitoring:

Non-medical case managers must contact the client within 60 days after completing an initial or reassessment individualized care plan. The general monitoring contact should assess the client's service needs and satisfaction; this can be done through telephone, face-to-face contacts, emails, etc.

Discharge Summary from NMCM (Item E)

A non-medical case management agency that utilizes *individualized care plans* may use Discharge Summary for a variety of options, such as: to indicate the client has satisfactorily met the goals of their care plan, the client has moved out of jurisdiction, the client is no longer in need of non-medical case management, the client is lost to care or can no longer be

located, the client's needs are more appropriately addressed in another program such as medical case management, the client exhibits a pattern of abuse as defied by agency's policy, or the client has deceased.

To determine if client is lost to care or cannot be located, the subrecipient will attempt and document 3 follow-up contacts over a period of time, i.e., contacts are not to be conducted on the same day. Examples of a client being lost to care or cannot be located include: the client is non-responsive to agency contacts regarding referral follow-up, or the client is non-responsive to agency attempts at complete a 60-day general monitoring check-in. The reason for a discharge summary must be notated in CAREWare within the service notes.

Personnel Qualifications (including licensure)
Non-medical case management is provided by non-medical personnel but shall have had at least six (6) months of relevant experience in the areas of outreach work, community services, supportive work with families and individuals, aging, supportive work with youth, corrections, or public relations. The suggested minimum educational experience shall be a B.A. or B.S. degree in any of the following disciplines: psychology, social work, counseling, sociology, community health, and public health or an associate degree with three years in a related field. If qualified individuals do not have relevant and current experience related to working with individuals living with HIV, they must receive HIV specific training within six months of hire.

Other Professional Services: Legal Services

SERVICE CATEGORY DEFINITION

Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:

- Assistance with public benefits such as Social Security Disability Insurance (SSDI).
- Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Programs.
- Preparation of:
    - Healthcare power of attorney.
    - Durable powers of attorney.
    - Living wills.
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney.
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.

Program Guidance: Legal services exclude criminal defense and class-action suits.
OoH recommends that all agencies utilize validated best practices for the execution of their

service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Recipient Office and we will provide the necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on clients.

Currently Funded Legal Services

- Intake
- Intervention
- Brief Service
- Class/Clinic

Service Delivery

Legal Services provided to Ryan White Part B clients must be directly necessitated by the individual's HIV status. Clients receiving Legal Services are prescreened (item A from above) by intake and referral specialists (Legal Service Advocate/Paralegal/Case Manager) with the providing agency to determine if there needs to be an escalation to a legal service intervention (item B from above). If a client's request is determined to warrant legal advice, an attorney licensed to practice law in Nevada will provide legal advice. Legal Services will be evaluated on the number of cases opened during a reporting period where an attorney gave legal advice or provided legal intervention. If a client does not need legal action the services performed by the Legal Service Advocate/Paralegal fall under item C from above.

Classes or clinics that are facilitated by a legal services advocate must be within the scope of allowable topics of issues necessitated by a person living with HIV.

Personnel Qualifications (including licensure)

Legal Service Intake, Assessment, and Counseling can be provided by non-medical personnel but shall have had at least six months of relevant experience in the areas of outreach work; community services; supportive work with families and individuals; geriatrics; supportive work with youth; corrections; or public relations. The minimum educational experience shall be a B.A. or B.S. degree in any of the following disciplines: psychology, social work, counseling, sociology, community health, and public health or an associate degree with three years in a related field. If qualified individuals do not have HIV related experience, they must receive HIV specific training within six months of hire. These staff members must be supervised by a licensed attorney with the State Bar of Nevada.

Legal Service Interventions for PLWH must be provided by a licensed attorney with the State Bar of Nevada. Law students, law school graduates and other legal professionals will be supervised by a qualified licensed attorney. Law students who make court appearances must have a current certification from the State Bar of Nevada.

References and further reading

American Bar Association – AIDS Impact Project
HIV/AIDS Bureau – National Monitoring Standards for Ryan White Part B Grantees: Program – Part B; April 2013.
HIV/AIDS Bureau – Policy Clarification Notice 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Use of Funds, January 2016.

Las Vegas TGA – Ryan White Part A HIV/AIDS Program, Service Standards
Nevada Office of HIV/AIDS Policy Eligibility & Enrollment for Ryan White Part B
Ryan White HIV/AIDS Program Service Report Instruction Manual, December 2021
The Center for HIV Law & Policy

Other Professional Services: Tax Preparation

SERVICE CATEGORY DEFINITION

Other Professional Services allow for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Income tax preparation services assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance: Tax Preparation Services may be provided through:

- Contracts with providers of tax preparation services through vouchers

Unallowed costs include:

- Direct cash payments or cash reimbursements to client
- Reimbursement to a tax preparation service not contracted with sub-recipients.

Service Delivery
Customer will come into the sub-recipient providing Tax Preparation services for a voucher to be able to go to available tax preparation services. If there are additional costs, the client will bring back an invoice from the tax preparation service to be paid for by the sub-recipient.

Outreach Services

SERVICE CATEGORY DEFINITION

The Outreach Services (Retention-in-Care) category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities:

- Identification of people who do not know their HIV status and/or
- Linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must use data to target populations and places that have a high probability of reaching PLWH who:

- have never been tested and are undiagnosed,
- have been tested, diagnosed as HIV positive, but have not received their test results, or
- have been tested, know their HIV positive status, but are not in medical care.
- be conducted at times and in places where there is a high probability that PLWH will be identified; and
- be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV, or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Personnel Qualifications (including licensure)
The minimum educational experience shall be a High School Degree or GED. If qualified individuals do not have relevant and current experience related to working with individuals living with HIV, they must receive HIV specific training within six (6) months of hire.

Service Delivery
Linkage to Care
Linkage activities assist the clients in accessing core and support services including making appointments for the following indicated categories: outpatient ambulatory health services, medical case management, non-medical case management, mental health services, etc. Linkage activities assisting clients in accessing support services fall under this service name, as well.

Client Finding
Client finding activities must comply with HRSA/HAB policies, standards, and definitions of Outreach Services. Specifically, broad scope activities such as providing ‘leaflets at a subway stop’ or, ‘a poster at a bus shelter’ would not meet the intent of the law. Activities must be planned and delivered in coordination with the state and local jurisdiction’s HIV Prevention Program. They must be directed and targeted at populations known to be disproportionately at risk for HIV infection and conducted in a manner to quantitatively evaluate their effectiveness.

Health & Wellness Engagement/Reengagement

Initial contacts are made through the Retention in Care Project for clients who might be marginally connected to care by having an alternate payer source other than the NMAP for their medications or who have lapsed in their Nevada Ryan White HAP enrollment. These can be via telephone, digital, in-person, etc. At least one contact or two attempts to contact must be made with each client in the Retention in Care Project with the result of that contact being captured in the RiC Subform in CAREWare.

Staff will complete a standardized contact and short assessment with all clients to determine readiness and need for services, considering the following factors:

- barriers to enrollment in RWPB and adherence to medications and medical care.
- history of adherence.
- treatment, and opportunistic infections; and
- the sufficiency of self-management and to provide.
- referrals, when appropriate, to prevent lapses in care.

Referral & Related Activities
Referral and Related Activities should be used to help the eligible individual obtain needed services through referrals internal and external to CAREWare, including activities that help link the individual with medical, social, and support providers or other programs and services that can provide needed services to address identified needs. Referral and related activities should also be used when Outreach Services workers/coordinators/specialists follow-up on a referral made to another provider to ensure completion or rejection of a referral, or when following-up with a client to ensure the client's needs have been met.

Referrals: After each initiated referral, workers/coordinators/specialists must conduct a 30-day follow-up on a referral made to another provider to ensure completion or rejection of a referral, or when following-up with a client to ensure the client's needs have been met. *Internal Referrals* should be closed out in CAREWare by the receiving agency, *External Referrals* should be closed out by the initiating agency.

Below is an overview of the outreach services process, which includes the items described above:

1. Identify & Locate Clients
    - Go into the community (e.g. shelters, community centers, community events, encampments, clinics, etc.).
    - Partner with testing sites or community-based organizations to find people who are HIV-positive but not in care.
    - Use data (e.g. CAREWare, referral reports) to find and contact people who have fallen out of care.

2. Engage & Build Trust
    - Conduct face-to-face interactions through outreach workers or peers (e.g. community health workers).
    - Provide culturally appropriate information about Ryan White services and medical care options (as described in the annual goals in the Clinical Quality Management plan).
    - Listen to barriers (e.g., transportation, stigma, fear, cost) and begin addressing them via a care plan and other dedicated resources outside of Ryan White, when possible.

Example:
An outreach worker meets a client at a food pantry who has missed HIV appointments.

Barrier Identified: The client says they lost the clinic's phone number and didn't know how to reschedule their appointment.
Action: Outreach worker provides the clinic's number and helps the client call right there to set a new appointment.
Follow-Up: A quick check-in calls the next week confirms the client went to the appointment. The outreach worker documents the contact and outcome in CAREWare.

3. Linkage to Care
- Directly refer clients to HIV medical providers, eligibility/enrollment staff, or case managers (e.g. medical or non-medical).
- Refer to appropriate agencies for assistance with paperwork/case management services, based upon the payor source. Any paperwork assistance should be for Ryan White services, with referrals to appropriate agencies for any service outside of the recipient's funding.
- Follow up to confirm the person made it to care (i.e., not just a handoff). This can include making additional contact to ensure care has been received.

4. Documentation
- Track each outreach contact in CAREWare, (date, location, outcome) if client is non eligible track data on excel spreadsheet provided by Ryan White Part B Coordinator and send to the State monthly when RFR's are submitted.
- Report numbers of:
- People reached
- People tested (if the agency conducts testing only) HIV+ clients identified
- Clients linked to care

5. Coordinate with Recipient (the State)
- Share outreach outcomes in reports (e.g., annual progress report, Clinical Quality Management).
- Cooperate with monitoring visits to show compliance with HRSA and State of Nevada guidance.
- Participate in Quality Improvement Projects (e.g., if linkage numbers are low, adjust approach).

From a subrecipient standpoint, outreach is boots-on-the-ground work:

- Finding PLWH not in care
- Talking with them directly
- Linking them into medical care
- Documenting the outcomes

Reference Health Resources Services Administration 's PCN 16-02 Clarifications on Outreach and Eligibility

Psychosocial Support Services

SERVICE CATEGORY DEFINITION

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respite support

- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance: Funds under this service category may not be used to provide nutritional supplements (See HRSA PCN 16-02). Ryan White HIV/AIDS Program (RWHAP) - funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. Funds may not be used for social/recreational activities or to pay for a client's gym membership. For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

Note: Psychosocial Support Services funded by Nevada Part B shall be evidence-based whenever practicable.

OoH recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Grantee Office and we will provide necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on clients.

Currently Funded Psychosocial Support Services

A. Non-Clinical Support Group

Service Delivery
The Psychosocial Support Services (PSS) provided to Ryan White Part B clients are to include non-clinical support groups.

Personnel Qualifications (including licensure)
Psychosocial Support Services staff shall be trained and knowledgeable about HIV/AIDS, the affected communities, and available resources. Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications including generally accepted psychosocial interventions and practices. Pastoral Care/Counseling Services Staff shall be provided by an institutional pastoral care program with a licensed or accredited provider of such service.

References and further reading
HIV/AIDS Bureau – National Monitoring Standards for Ryan White Part B Grantees: Program – Part B; April 2013.HIV/AIDS Bureau – Policy Clarification Notice 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Use of Funds, January 2016. Las Vegas TGA – Ryan White Part A HIV/AIDS Program, Service Standards Nevada Office of HIV Policy Eligibility & Enrollment for Ryan White Part B
Ryan White HIV/AIDS Program Service Report Instruction Manual, September 2015.

Referral for Healthcare & Supportive: Eligibility

SERVICE CATEGORY DEFINITION

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication.

This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).
Program Guidance: Referrals for Health Care and Support Services provided by outpatient/ ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category. Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

The State of Nevada recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Grantee Office and we will provide the necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects on clients.

Currently Funded Referral to Health Care and Supportive Services Activities

A. Eligibility – Annual Review
B. Eligibility – Recertification
C. Eligibility – Other Contact
D. NMAP Coordination (NMAP only)
E. HIP CSAP Coordination (NMAP only)
F. Insurance Enrollment (NMAP only

Service Delivery
Eligibility – Annual Review [Item A]
Ryan White Part B subrecipients for Referral to Healthcare & Supportive Services: Eligibility & Enrollment must conduct a comprehensive annual eligibility assessment of a client to determine the ability of that client to access other RWPB services. Clients must be reassessed every six (6) months but can have a shorter self-assessment/recertification six months after their Annual Review. Clients may be given a grace period for the completion of the annual and recertification application as determined by the Eligibility Specialists complying with the minimal required documentation:

- Proof of HIV Diagnosis
- Proof of Residence
- Proof of Income at or below 400% FPL

However, the eligibility process can only be finalized when all documentation required is provided. A copy of the Universal Eligibility Application is required for initial eligibility.

- Proof of HIV Diagnosis
- – Possible move to NMCM/MCM move to NMAP Proof of Nevada Residency

- Proof of Low-Income Status (income and household size to determine federal poverty level)

Eligibility – Recertification [Item B]
Enrollment must be recertified six months after an Annual Review. Eligibility Specialists will update client eligibility files and provide the state with the recertified application and supporting documentation at that time. This is done by using the six-month self-attestation documentation, and client change of information forms if there are any changes. The recertification process may be completed by mail or phone. Clients may be given a grace period for the completion of the recertification process as determined by the Eligibility Subgrantee. If a client has not recertified prior to the expiration of their current benefits, they may be dropped from all elements of the RWPB program.

Eligibility – Other Contact [Item C]
This is to be used for all subsequent follow-up contacts/interactions with an active client or the client's record between their initial Annual Review service and the Recertification service. (i.e., client drops off remainder of documents, client is called to be reminded of appointment, client is called to be told of eligibility end date, client's record is reviewed/no actual contact is made but the record is touched).

Responsibilities of Clients
After an initial enrollment, clients are responsible for updating their eligibility criteria every six months. The client is also responsible for reporting any changes to their income or insurance status between eligibility appointments. Clients must make a recertification appointment before the expiration date of their benefits.

NMAP Coordination (NMAP only) [Item D]
NMAP Coordination should be used when working with clients related to referring a client to NMAP services. Examples include obtaining NMAP-related documents from clients or employers, entering client data into the Ramsell Corporation State Government Solutions LLC Pharmacy Benefit Management system, making health insurance premium payments on behalf of a client, coordinating with pharmacies on behalf of a client, etc.

HIP CSAP Coordination [Item E]
HIP CSAP Coordination should be used when working with clients on a referral related to Health Insurance Premium and Cost Share services. Examples include coordinating with clients or medical providers related to a client's medical/vision/dental cost share or copayments, making dental insurance premium payments on behalf of a client, obtaining Health Insurance Premium and Cost Share back-up documentation from clients, etc.

Insurance Enrollment (NMAP only) [Item F]
To be used when referring a client to NMAP services for enrollment in any health insurance plan (private individual plan, marketplace plan, Medicaid, Medicare, COBRA, etc).

Responsibilities of Eligibility & Enrollment Provider
Eligibility screening has transitioned from a paper-based system to a computer-based system with the implementation of CAREWare. The CAREWare system was built by HRSA

and is maintained and updated regularly throughout the year. The subgrantees conducting eligibility screening for the RWPB Program are responsible for maintaining complete, accurate and up-to-date client-level information. The eligibility subgrantees are required to verify, scan, and upload into CAREWare supporting documentation demonstrating the client's eligibility as well as other necessary documents and forms (consent forms, client rights, HIPAA acknowledgment, releases of information, etc.). All documents related to the application process, including the application, Proof of Diagnosis, Proof of Residency, Proof of Income, and any identification or insurance documentation, should be uploaded as a single PDF file.

If an applicant has a unique circumstance or if eligibility is not conclusive the applicant should not be given an initial authorization for services but should be told they will be contacted once the question has been clarified. Once a determination has been made, the initial application can be processed as approved or denied by the subgrantee. The State holds secondary application reviews and reserves the right to approve or deny based on the application information or request for further documentation.

The Eligibility & Enrollment providers will make the eligibility determination for all RWPB applications per HRSA and state criteria. Any denial of RWPB services must be issued to the applicant in writing at the time of denial or by letter with proof of mailing. All denials are reviewed by the State. Clients can appeal the decision. If clients have any change in their information regardless of the timing during their recertification cycle, the change must be documented immediately within the client's file with copies submitted to the state. Failure of a client to provide timely documentation of a change in information that may impact eligibility will result in a termination of benefits.

Waivers
From the general RWPB rules may only be granted by the State for unique and verifiable circumstances. Please call the Nevada RWPB office if you have a client with a special need. Vacation waivers are granted upon state approval.

Due Diligence
At any time, an enrollee's eligibility may be investigated by the eligibility subgrantee. Eligibility Specialists will document the reason for suspected ineligibility, perform their investigation and relay the findings to the State RWPB Program.

Personnel Qualifications (including licensure)
Referral to Health Care and Supportive Services: Eligibility and Enrollment services are provided by non-medical personnel but shall have had at least six months of relevant experience in the areas of outreach work; community services; supportive work with families and individuals; aging; supportive work with youth; corrections; or public relations. The minimum educational experience shall be a High School Degree or GED. If qualified individuals do not have relevant and current experience related to working with individuals living with HIV, they must receive HIV specific training within six months of hire.

References and further reading

HIV/AIDS Bureau – National Monitoring Standards for Ryan White Part B Grantees: Program – Part B; April 2013.
HIV/AIDS Bureau – Policy Clarification Notice 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Use of Funds, January 2016.
Las Vegas TGA – Ryan White Part A HIV/AIDS Program, Service Standards
Ryan White HIV/AIDS Program Service Report Instruction Manual, September 2015.

SERVICE STANDARDS CHANGE LIST

Overall

Change	Date
Condensed the Service Standards into a single document	September 5, 2023

Section 1: Universal Standards

Eligibility

Change	Date
Separated from Non-Medical Case Management and placed it in Universal Standards to list eligibility requirements for Ryan White as being for all services.	September 5, 2023
Created a table showing what documentation is needed for each part of the eligibility process.	September 5, 2023
Payor of Last Resort section added to eligibility.	September 5, 2023
Discharge, Transition, and Case Closure moved out of Non-Medical Case Management into eligibility.	September 5, 2023
Client Rights and Responsibilities added to eligibility.	September 5, 2023
General personnel requirements moved to eligibility.	September 5, 2023
Added definitions for Enrollment Status Options	October 23, 2024

- This section left blank -

Section 2: Universal Standards

Health Insurance Premium and Cost Sharing (HIP-CS)

Change	Date
Policy and Procedure 15-03 added to the Service Standards document	September 5, 2023
Change eligibility criteria to be a bullet list.	September 5, 2023
Added clarification on CAREWare Service Category	June 12, 2024

Medical Case Management

Change	Date
Policy and Procedure 15-06 added to the Service Standards document	September 5, 2023
Added bullet list of currently funded Medical Case Management activities.	September 5, 2023
Removed section on Medical Case Management eligibility as it matches same requirements as standard eligibility.	September 5, 2023
Discharge planning moved from Medical Case management to Universal Eligibility.	September 5, 2023

Medical Nutrition Therapy

Change	Date
Policy and Procedure 19-03 added to the Service Standards document.	September 5, 2023

Mental Health Services

Change	Date
Policy and Procedure 19-03 added to the Service Standards document.	September 5, 2023
The Funded Services list was reduced from 7 items to 4.	September 5, 2023
Clinical Intervention, Non-Clinical Intervention, and Acupuncture Services removed from list of funded services.	September 5, 2023
Clinical Group Counseling renamed Mental Health Group Counseling	September 5, 2023
Individual Counseling renamed Mental Health Individual Counseling	September 5, 2023

Nevada Medication Assistance Program

Change	Date
Policy and Procedure 15-05 added to the Service Standards document.	September 5, 2023
Removed repetitive list of NMAP services.	September 5, 2023
Added Outpatient Ambulatory Health Services, Cabenuva Only as a funded service.	September 5, 2023
Added Outpatient Ambulatory, Health Services, Sunlenca Only as a funded service.	October 1, 2023

Added Medicare explanation table found in HRSA PCN 18-01 to differentiate the different parts.	October 20, 2023
Added clarification on source of payment date uploaded into CAREWare whether it is from Prime Therapeutics or NMAP provider.	November 22, 2024
Removed need for NMAP subrecipients to verify Proof of Diagnosis and Proof of Residency when completing NMAP referrals.	October 20, 2023
Changed steps for how to handle a rejected referral for non-emergency referrals.	October 20, 2023
Changed steps for how to handle a rejected referral for emergency referrals.	October 20, 2023
Added list of NMAP medication categories showing insurance types that NMAP can assist with.	October 20, 2023
Changed "Insured" category to "Private Individual" to match RSR categories.	October 20, 2023
Changed "Employer Sponsored Insurance" category to "Private Employer" to match RSR categories.	October 20, 2023
Changed "Uninsured" category to "No Insurance" to match RSR categories.	October 20, 2023
Updated formulary information including medications covered.	October 20, 2023
Removed "Licensing, Knowledge, Skills, and Experience" sections.	October 20, 2023
Removed "Summary, Recommendations, and References and Further Reading," sections.	October 20, 2023
Removed 30-day limit for No Insurance clients	May 29, 2024
Removed 30-day limit for emergency referrals	May 29, 2024
Removed disenrollment requirement if client does not use NMAP for 90-days	May 29, 2024
Added clarification on CAREWare Service Category	June 12, 2024
Removed requirement for the NMAP agency to review income for a referred client.	December 16, 2024
Listed the requirement that the referring agency must include all necessary documentation and information before sending a referral.	December 18, 2024
Added clarification on private-employer documentation needed	February 4, 2025
Added definition of "Bridge Coverage"	February 4, 2025

Outpatient Ambulatory Health Services – Cabenuva

Change	Date
New service category added to the Service Standards document.	September 5, 2023

Outpatient Ambulatory Health Services – Exempt Cabenuva and Sunlenca Injection Services

Change	Date
New service category added to the Service Standards document for northern Nevada subrecipient only.	February 4, 2025

- This section left blank -

Section 3: Support Services

Emergency Financial Service

Change	Date
New Service category added to the Service Standards document.	April 1, 2023
Category is not currently funded	April 1, 2023

Health Education/Risk Reduction

Change	Date
Removed "Health & Wellness Engagement/Reengagement (RiC)" from funded services.	April 1, 2023
Policy and Procedure 15-08 added to the Service Standards document.	September 5, 2023
Removed eligibility guidelines and moved them to Universal Standards.	September 5, 2023
Removed qualifications and licensure and moved to Universal Standards.	September 5, 2023

Housing Services

Change	Date
Policy and Procedure 17-11 added to the Service Standards document.	September 5, 2023
Removed "Service goals and Objectives."	September 5, 2023
Removed eligibility guidelines and moved them to Universal Standards.	September 5, 2023
Removed "Licensing and Experience, Summary, and Recommendations."	September 5, 2023

Medical Transportation

Change	Date
Policy and Procedure 15-11 added to the Service Standards document.	September 5, 2023
Removed eligibility guidelines and moved them to Universal Standards.	September 5, 2023
"Van Ride" service removed from list of Rural Transportation options.	September 5, 2023

Non-Medical Case Management

Change	Date
Policy and Procedure 15-05 added to the Service Standards document.	September 5, 2023
Added "Encourage clients to get annual CD4 and Viral Load labs" to activities.	September 5, 2023
Removed "Service Goals and Objectives" from standards.	September 5, 2023
Removed eligibility guidelines and moved them to Universal	September 5, 2023

Standards.	
Removed "ADAP Coordination" from funded services.	September 5, 2023
Removed "HIP CSAP" from funded services.	September 5, 2023
Removed "Health & Wellness Engagement/Reengagement (RiC)" from funded services.	September 5, 2023
Added "Individualized Care Plans" to Initial Assessment/Development" service.	September 5, 2023
Added guidance on follow-up for Referrals within 30-days.	September 5, 2023
Added guidance on follow-up for General Monitoring within 60 days.	September 5, 2023
Removed Section V, "Process."	September 5, 2023
Removed Section VI "Non-Medical Case Management Non-Eligibility Agencies."	September 5, 2023
Condensed section VII to "Personnel Qualifications" in Service Standards document.	September 5, 2023
Removed section VIII "Summary"	September 5, 2023
Removed Section IX "Recommendations."	September 5, 2023

Other Professional Services: Legal Services

Change	Date
Policy and Procedure 15-10 added to the Services Standards document.	September 5, 2023
Removed eligibility guidelines and moved them to Universal Standards.	September 5, 2023
Changed "Licensing, Knowledge, Skills, and Experience," to "Personnel Qualifications (Including Licensure)."	September 5, 2023
Removed section VII "Summary."	September 5, 2023
Removed section VIII "Recommendations."	September 5, 2023
Removed "Income Tax Preparation" as a funded service.	October 30, 2023

Other Professional Services: Tax Preparation

Change	Date
Created new Policy and Procedure and added it to the Service Standards documentation.	September 5, 2023

Outreach Services

Change	Date
Removed "Health and Wellness Engagement/Reengagement (RiC)" from Non-Medical Case Management and created new service category and added it to the Service Standards document.	April 1, 2023

Psychosocial Support Services

Change	Date
Policy and Procedure 15-13 added to the Service Standards Document.	September 5, 2023

Removed “Service Goals and Objectives,”	September 5, 2023
Removed eligibility guidelines and moved them to Universal Standards.	September 5, 2023
Changed “Licensing, Knowledge, Skills, and Experience,” to “Personnel Qualifications (Including licensure).”	September 5, 2023
Removed “Summary” and “Recommendations” sections.	September 5, 2023

Referral for Healthcare and Supportive Services: Eligibility

Change	Date
Removed “Eligibility” sections form Non-Medical Case Management and created new Service Category and added it to the Service Standards document.	April 1, 2023
Clarified that (ADAP Only) services are intended for the act of sending a referral for the given service and not the act of providing the service.	June 12, 2024

- This section left blank -

REVISION SCHEDULE

Published	*April 7, 2023*	*Located at: https://endhivnevada.org/ryan-white-part-b-documents/*
Revised	*April 19, 2023*	*Located at: https://endhivnevada.org/ryan-white-part-b-documents/*
Revised	*June 16, 2023*	*Located at: https://endhivnevada.org/ryan-white-part-b-documents/*
Revised	*September 5, 2023*	*Located at: https://endhivnevada.org/ryan-white-part-b-documents/*
Revised	*June 12, 2024*	*Located at: https://endhivnevada.org/ryan-white-part-b-documents/*

- This section left blank -