

SERVICE CATEGORIES

The following Ryan White Part B services are currently covered by the Consortium:

CORE SERVICES

- Outpatient/Ambulatory Health Services
- AIDS Pharmaceutical Assistance (local)
- Oral health care
- Mental Health Services
- Medical Case Management (including treatment adherence)
- Substance Abuse Services-Outpatient

SUPPORT SERVICES

- Case Management (Non-Medical)
- Medical Transportation Services
- Substance Abuse Services (Residential)

All services covered by the Ryan White CARE Act are only guaranteed based on availability of funds.

The following allowable Ryan White Part B services are **not** currently covered by the Consortium:

CORE SERVICES

- Early Intervention Services
- Health Insurance Premium & Cost Sharing Assistance
- Home Health Care
- Home and Community-Based Health Services
- Hospice Services
- Medical Nutrition Therapy

SUPPORT SERVICES

- Childcare Services
- Emergency Financial Assistance
- Food bank/home-delivered meals
- Health education/risk reduction
- Pediatric developmental assessment/early intervention services
- Permanency Planning
- Housing services
- Linguistics Services
- Outreach Services
- Psychosocial Support Services
- Respite Care
- Rehabilitation Services
- Treatment Adherence Counseling

PRIORITY OF SERVICES

The Consortium has agreed on the following services (in order of importance) as priorities for the region:

1. Outpatient/Ambulatory Health Services*
2. AIDS Pharmaceutical Assistance (local)*
3. Oral health care*
4. Medical Case Management (including treatment adherence)*
5. Case Management (Non-Medical)
6. Medical Transportation Services*
7. Mental Health Services*
8. Substance Abuse Services-Outpatient*
9. Substance Abuse Services (Residential)

*VDH Priorities

CAPATATIONS, EXCEPTIONS AND EXCLUSIONS

Capitations: Capitations are a dollar amount that is normally 125% of the Consortium’s average cost for a service. This is a cost tracking tool for subcontractors and not a restriction on services or providers.

Exclusions: Exclusions are services, which have been determined to be unallowable by the Consortium, the Virginia Department of Health (VDH) or the Health Services and Resources Administration (HRSA). Excluded service items may not be paid for under Ryan White Part B funds and must be referred to other assistance funds.

Service Limits: Service Limits are the maximum allowable dollar amount that a single client may receive for a single service category.

Salary Based Services: Some services under the scope of the Consortium may be provided through a salary based system where the Ryan White funds pay for a qualified individual to deliver the services. Record keeping for salary based services differs from fee for service billing as it records time spent working on the clients case rather than a set fee per visit.

- Unit of services is 15 minute segment of time
- Face to face units are
- Non-face to face units are those where the communication with
- Other units are time spent working on the behalf of the client. It may also include activities conducting chart maintenance or data entry into the statewide data collection system.

No-Show Rule: Subcontractors have the right to suspend, temporarily or permanently, any or all services to clients who habitually (3 or more) miss provider appointments. Subcontractors who wish to use the “No-Show Rule” must include the rule in the client agreement to receive services. Consortium Subcontractors may not pay service providers for missed appointments except in the case of transportation providers for actual mileage costs.

Interest Charges: Interest charges may not be paid for any services under Ryan White Part B

VDH Medication Policy: Effective October 1, 2006, all medications purchased/reimbursed by S/PHCC subcontractors must comply with the Medication Policy issued by the Virginia Department of Health. A copy of this policy has been included under Medications.

CORE SERVICES

Ambulatory/Outpatient Medical Care: is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings (See Emergency room visits below). Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. For the purposes of Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 ALL medical services MUST be related to HIV infection and it's treatment.

Third Party Payment: For the purpose of Peer reviews, subcontractors who use third party providers must obtain the following information:

1. Medical history, physical examination, laboratory reports, medications and treatments, plan of care.
2. Interim progress notes, laboratory reports.
3. Referrals and follow-ups
4. All reports must be signed and dated.

Any subcontractor using a third part medical provider for HIV or specialty care must have a written memorandum of Agreement (MOU) spelling out the program requirements for chart documentation, prevention message, billing process, etc.. Subcontractors have the option of Peer Review team site visits at local provider(s) if documentation cannot be maintained in the client's charts. This option must be documented in writing with the provider prior to any services paid for by Ryan White Part B funds each year. A copy of the agreement must be on file with the lead agency to ensure adequate planning for peer review site visits.

Prevention Services for HIV Positive Clients: Subcontractors shall ensure that all primary medical/routine HIV care services, for which reimbursement is provided under this subcontract, shall include a prevention message.

Early Intervention Services (EIS): EIS includes activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Part A & B of the Ryan White program, includes outreach, counseling and testing, information and referral services. Under Part C of the Ryan White program EIS also includes comprehensive primary medical care for individuals living with HIV/AIDS. According to VDH Policy, EIS will be funded only if federal, state and local funds are inadequate for the EIS services the entity proposes to provide and the funds will supplement, not supplant, other funding for EIS. Any request for funding of EIS services, must include documentation of other EIS funded programs in the region.

The Southwest/Piedmont HIV Care Consortium has agreed to cover medical services as follows:

1. **Office Visits:** All clients are required to have a primary care physician, or an infectious disease physician willing to act as a primary care physician, documented in their chart. Visits to a client's infectious disease physician will be covered if the visits are HIV-related.
2. **Primary Care:** One visit (check-up) per year to a Primary Care Physician is allowed.
3. **Referrals to Specialty Care:** Visits to other sub-specialists, such as ophthalmologists, cardiologists, gynecologists, psychiatrists, otolaryngologist, podiatrists, and endocrinologists, will be covered only if referred by the **infectious disease physician** (or **qualified primary care physician** if no ID physician is available) to treat HIV-related disorders. Tests and procedures by this sub-specialist may require additional approval.
4. **Psychiatric Visits:** Non-counseling visits for the management of psychotropic medications are allowed under ambulatory/outpatient care. Counseling visits must be billed under mental health/counseling.
5. **Emergency Room Visits:** Consortia subcontractors are required to provide a 24 hour/7 day coverage plan. Subcontractors may refer clients to an emergency room for care if the client has contacted their **infectious**

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disease physician (or qualified primary care physician) and physician refers the client to the emergency room (documentation is required in the chart). Emergency Room visits are to be pre-approved whenever possible. Emergency room visits by clients who utilize services in place of primary care will not be covered.

6. **Optometrist/Ophthalmologist Visits:** Infectious disease or primary care physicians may refer clients for an eye exam if there is a suspected HIV-related vision problem, however, unless an HIV-related problem is detected, no further services may be paid by Ryan White Part B. Glasses or any other corrective eye wear may not be purchased with Part B funds at any time.
7. **Diagnostic/Laboratory Testing:** Tests commonly used to monitor progression of HIV disease and for the purpose of treating HIV-related disorders are covered. Tests used to diagnose disorders commonly found in clients with HIV disease are also covered.

Physician Visits/Specialty Care

Unit of Service: 1 Physician visit

Capitation: The cost per unit of Service is **\$106.00**

Exclusions: The following services are not covered with Ryan White Part B funds:

- **Immunizations:** Vaccinations will be covered if not covered by ADAP and the client has no other method of paying for them. Vaccinations are considered medications for the purpose of Ryan White Part B.
- Cancer, except in the case of cancers that are AIDS-defining conditions
- Inpatient care
- Abortions
- Emergency Room visits for Primary Care

Service Limits: None

Laboratory /Diagnostic Services

Unit of Service: 1 laboratory or diagnostic test.

Capitation: The cost per unit of Service is **\$83.00**.

Exclusions: The following services are not allowed under Ryan White Part B -

- Mammograms
- Prostate Specific Antigen tests
- Any cancer diagnostics, except in the case of cancers that are AIDS-defining conditions.

Service Limits: None

CORE SERVICES

AIDS Pharmaceutical Assistance : Includes medications associated with HIV and related conditions as set forth in the Virginia Department of Health Non-ADAP Drug Formulary (Full and Co-payment assistance) and ADAP Formulary (Co-payment assistance only).

VDH Policy on Non-ADAP Drug Formulary: This policy replaces Consortia Purchase of Non-ADAP HIV Related Drugs, dated November 14, 2003. Part B policy requires that all services provided using Ryan White dollars be explicitly related to the client's HIV diagnosis. Medications are often used for a variety of purposes and determining how the use of each drug prescribed is related to a client's HIV diagnosis can be difficult. In order to ensure that basic drugs needed to treat HIV-related conditions are available in all areas of the state, VDH has developed a Part B non-ADAP formulary.

- Effective October 1, 2006, only drugs listed on the approved VDH non-ADAP formulary may be purchased with Part B dollars.
- Part B funds may not be used for medications available through ADAP unless the delay in treatment would endanger the individual's health (for example when opportunistic infection treatment is warranted). Coverage is limited to no more than a 5-day supply.
- For clients with third party insurance including Medicare and Medicaid, co-pays for medications can only be reimbursed for drugs listed on the ADAP formulary and the non-ADAP formulary.
- Any client receiving Part B assistance with costs of medications who is also enrolled in Medicare is strongly encouraged to enroll in a Medicare prescription drug plan. Part B resources can be used to pay Medicare cost sharing including premiums, deductibles, and co-pays.
- Brand name formulations of medications on the formulary may be paid for with Part B funds only if a generic formulation is not available. Brand names are listed on the formulary as a reference only.
- If a drug is listed on the formulary and it is available in both prescription and over-the-counter (OTC) strengths, the OTC version can be purchased with Part B dollars. Other than drugs listed on the formulary with OTC versions, OTC medications cannot be purchased with Part B dollars.
- Compound drugs listed on the formulary may be paid for with Part B funds. If only the separate components are listed, the compound formulation is not covered.
- Part B funds may be used to cover the costs for any drug on the formulary without seeking prior approval from VDH. However, subcontractors should determine the reason the drug is being prescribed before payment is made. **Drugs on the formulary may only be paid for with Part B funds when the reason for the use of the drug is HIV related.** For example, you can pay for pain medication to treat neuropathy but not for pain medication to treat pain from injuries resulting from a traffic accident.
- Use of medications must be HIV related but is not restricted to the indication/use cited on the formulary. This information is provided only as an information resource.

Review of Formulary:

- VDH will review the formulary at least annually.
- Primary care providers may make requests for additions to the formulary in writing to:
 - Diana Jordan, Director
 - Health Care Services
 - Division of Disease Prevention
 - Virginia Department of Health
 - P.O. Box 2448
 - Richmond, VA 23218-2448
- Requests for additions to the formulary must include the following information:
 - Name of the drug, generic and brand name
 - Reason why drug should be added
 - If other drugs to treat the same condition are already included on the formulary, how is this drug better than approved alternatives
 - How condition the drug treats is related to HIV infection

Documentation: Medication assistance providers must maintain the following documentation for each prescription in the agency and/or client records:

- Name, dosage, and frequency of medication
- Name of prescriber
- Amount paid for prescription
- Any documentation related to reason for use of the drug, HIV relatedness, use of lower cost alternatives or other pertinent issues.

Lead agencies will perform a random selection and review of this documentation during site visits to subcontractors.

Regional Policies: Any regional policy must be in compliance with state policy. Consortia may further restrict allowed drugs, if needed, due to funding constraints. However, regions may not restrict access to ADAP medications by refusing to pay co-pays for clients with third party insurance.

Guidance

- In order to maximize availability of funds, every attempt should be made to provide cost effective treatment. Clinically appropriate, less costly alternatives should be used first whenever possible. Lead agencies may request documentation to this effect from subcontractors as needed.
- Pharmaceutical Assistance Programs offered by medication manufacturers provide an option for obtaining some medications at no or very low cost. Utilization of these programs for any medication required for greater than one month is strongly encouraged.

Definition of how a medication is HIV related – Medications are considered HIV-related if one of the following is true:

1. It is used to treat HIV infection.
2. It is used to treat opportunistic infections.
3. It is used to treat immediate and/or long term side effects of medications used to treat HIV or opportunistic infections with the following considerations:
 - a. The side effect is known and documented from a reliable clinical source.
 - b. The medication causing the side effect must be currently in use or recently discontinued. In the case of a recently discontinued medication, the side effect condition must be monitored to ensure that the treatment continues to be appropriate.
 - c. Preexisting conditions may be treated if there is documentation of an increased side effect after the initiation of therapy.
4. It is used to treat conditions due to advanced HIV infection.

The Southwest/Piedmont HIV Care Consortium has agreed to cover ADAP and Non-ADAP medications as follows:

1. **Priority and availability of medications:** The following groups of medications are available in order of priority:
 - Level I: Medications on the ADAP formulary – **This covers health insurance co-payments/deductibles, gap medications and medications that cost less than the insurance co-payment only. Full payment is not covered.** This level is mandatory. No drug from this list may be refused so long as funds are available.
 - Level II: Medications to treat opportunistic infections on the non-ADAP formulary. This level is mandatory.
 - Level III: Medications to treat side effects of antiretroviral therapy on the non-ADAP formulary.
 - Level IV: Medications to treat anxiety and depression on the non-ADAP formulary.
 - Level V: Medications to treat pain on the non-ADAP formulary.
2. **Restriction on over the counter medications:** All Medications covered by the Consortium must be filled by a pharmacy. No over-the-counter medications are to be covered by Ryan White funding.
3. **Co-payments:** Charges must be actual insurance deductibles or co-payments for any source including Medicaid and Medicare. Capitations, discounts and denials are considered full payment.

4. **Vaccines:** Vaccines are considered medications for the purposes of Ryan White Part B.
5. **Gap ADAP medications:** Gap ADAP medications may be filled with Part B funds in accordance with VDH policy.
 - The request must be a medical emergency (A gap in HAART, acute infection on a Friday afternoon, etc.).
 - The medication may only be filled for the number of days it will take to obtain the medication from the health department (Limit to 5 days). A written statement is required for the patients file from the local health department clearly explaining the situation.
 - The lead agency must be notified immediately.Clients who repeatedly fail to reorder their medications on time should be referred to case management or other programs as is appropriate.
6. **ADAP medications costing less than insurance co-payments:** If the full cost of the medication is less than the insurance co-payment, subcontractor may pay for the amount. The information on the billing log must indicate that the cost is below the amount of the co-pay.
7. **Refusal of payment by insurance companies:** The refusal of an insurance company to cover an ADAP medication will not automatically qualify the charge for payment. Subcontractors and providers must verify coverage of any medication on the ADAP list with insurance providers. If the medication in question is not covered by insurance, the client is to be referred to the local health department.
8. **Indigent drug/Pharmaceutical assistance programs:**
 - Subcontractors must screen any person without insurance for indigent drug/pharmaceutical assistance services.
 - Indigent drug programs are not considered a payment source. Utilization of such programs is not required before Ryan White can pay for medications.
 - Pre-payment for medications through pharmaceutical assistance programs is sometimes required. Ryan White Part B does not allow for pre-payment of any service. The medication cannot be invoiced to the lead agency until it has been received by the client in its entirety. The subcontractor must document the client received the medication. If the client never receives the medication, the subcontractor would be responsible for the cost.

Unit of Service: 1 medication at a 1 month supply

Capitation: The cost per unit of Service is **\$56.00**.

Exclusions: None

Service Limits: Only medications on the S/PHCC Formulary may be covered.

Note: The S/PHCC ADAP/Non-ADAP Formulary is attached as an appendix to the policy manual.

CORE SERVICES

Oral Health Care: Includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Third Party Payment: For the purpose of Peer reviews, subcontractors who use third party providers must obtain the following information:

1. Treatment plan and estimate for any dental work other than a routine check up and cleaning.
2. Referrals and follow-ups
3. All reports must be signed and dated.

Any subcontractor using a third part dental provider for oral health care must have a written memorandum of Agreement (MOU) spelling out the program requirements for chart documentation, billing process, etc. Subcontractors have the option of Peer Review team site visits at local provider(s) if documentation cannot be maintained in the client's charts. This option must be documented in writing with the provider prior to any services paid for by Ryan White Part B funds each year. A copy of the agreement must be on file with the lead agency to ensure adequate planning for peer review site visits.

The Southwest/Piedmont HIV Care Consortium has agreed to cover dental care as follows:

Priority 1, Emergency care:

1. Procedures/treatments to treat oral manifestations/complications of HIV disease.
2. Procedures of a restorative nature, such as the filling of cavities.
3. Extractions necessary due to infection or decay.
4. Dental fitting and prostheses if the client is unable to maintain adequate nutrition due to dental deficiencies.

Priority 2, Non-Emergent care:

1. Prophylactic care including an annual visit for routine x-rays, cleaning and examination.

In the event that funding for oral health care is limited, priority 1 services will be rendered over priority two.

Not allowed: Teeth whitening, straightening or other cosmetic care.

Referrals: Referrals must be made by the ID physician (or **qualified primary care physician if no ID physician is available**).

Pre-approval: All dental care must be approved by each subcontractor prior to receiving services. The client must have an evaluation visit with a price estimate to submit to the subcontractor..

Unit of Service: 1 procedure

Capitation: The cost per unit of Service is **\$190.00**.

Exclusions: The following are **not** covered by the Consortium:

- Cosmetic dental care

Service Limits: None

CORE SERVICES

Mental Health Services: Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within Virginia to render such services. This typically includes psychiatrists, psychologists, clinical nurse specialist, and licensed clinical social workers.

Third Party Payment: For the purpose of Peer reviews, subcontractors who use third party providers must obtain the following information:

1. Treatment plan with diagnosis
2. Progress reports (minimum frequency is every three months)
3. Referrals and follow-ups
4. All reports must be signed and dated.

Any subcontractor using a third party counseling provider for mental health care must have a written memorandum of Agreement (MOU) spelling out the program requirements for chart documentation, billing process, etc. Subcontractors have the option of Peer Review team site visits at local provider(s) if documentation cannot be maintained in the client's charts. This option must be documented in writing with the provider prior to any services paid for by Ryan White Part B funds each year. A copy of the agreement must be on file with the lead agency to ensure adequate planning for peer review site visits.

The Southwest/Piedmont HIV Care Consortium has agreed to cover mental health therapy/counseling as follows:

1. Subcontractors must use the **most cost-effective services** such as local community service boards before using Ryan White funds for mental health therapy/counseling services or psychiatric services. Documentation must be in the client's chart that other resources were first sought and were unable to meet their needs.
2. **Referrals:** A referral from the infectious disease physician is necessary before Ryan White funds can be used. Ryan White is the payer of last resort.
3. **Psychiatric visits:** These are covered for counseling services only. Medical monitoring of psychotropic medications is not allowed under this category and must be invoices under outpatient care.

Unit of Service: 1 visit

Capitation: The cost per unit of Service is: \$75.00

Exclusions: The following services are not covered with Ryan White Part B funds:

- Substance Abuse Treatment
- Inpatient mental health treatment

Service Limits:

- **Counseling Services: \$75 limit per visit.**

CORE SERVICES

Medical Case Management Services (including treatment adherence): A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

The Southwest/Piedmont HIV Care Consortium has agreed to cover case management as follows:

1. **Standards:** All subcontractors must comply with the Virginia Department of Health Case Management Standards released on January 15, 2008
2. **Levels of Case Management:** Medical case management may be provided to clients who have documented needs for Comprehensive or Supportive levels of service as described within the VDH Case Management Standards. Medical case management MAY NOT be used to provide eligibility services as described under Limited level of service as described within the VDH Case Management Standards.
3. **Assignment of Cases:** Clients are to be assigned to ONE and only one case manager at ONE and only one service level (Comprehensive or Supportive). The assigned case manager is the primary service provider for that client. From time to time it is understood that for reasons of staffing (vacations, sick leave, field work, etc.) the primary case manager is not available to assist the client with necessary work. Other agency case managers may pitch in to assist the client and then report what was done to the assigned case manager in the most appropriate and expedient method.
4. **Primary goal:** Case management services are offered with the goal of helping clients attain a level of self sufficiency that allows transition from more intensive interventions to less.
5. **Personnel:** All subcontractors must notify the lead agency in writing of the hiring, separation or termination of a person employed as a case manager.
6. **Background Checks:** It is highly advisable for all subcontractors to conduct Virginia State Police and Department of Motor Vehicles background checks on all case managers under their employ.
7. **Travel:** Under the category of case management, travel expenses are allowed as a service fee with the following restrictions:
 - Travel must be used to carry out face-to-face visits with clients or for such activities that carry out the client's plan of care (For example, picking up a fuel assistance application for a home bound client not eligible for Medicaid Waiver).
 - Travel may not be used for hospital visits.
 - It may not be used to transport clients.
 - Travel may not be used for meetings, conferences and trainings.

Unit of Service: One 15 minute segment of time, face to face, non-face to face or other.

Capitation: NA

Exclusions:

- Case management may not be used for case finding activities (See Outreach/Referral to Services)

Service Limits:

- Mileage reimbursement may not exceed current state rate.
- Clients receiving medical case management services may not be enrolled simultaneously in non-medical case management.

CORE SERVICES

Substance Abuse Services (Outpatient): The provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Third Party Payment: For the purpose of Peer reviews, subcontractors who use third party providers must obtain the following information:

1. Clients Treatment plan
2. Progress reports (minimum frequency is every three months)
3. Referrals and follow-ups
4. All reports must be signed and dated.

Any subcontractor using a third party substance abuse counseling provider for substance abuse treatment must have a written memorandum of Agreement (MOU) spelling out the program requirements for chart documentation, billing process, etc. Subcontractors have the option of Peer Review team site visits at local provider(s) if documentation cannot be maintained in the client's charts. This option must be documented in writing with the provider prior to any services paid for by Ryan White Part B funds each year. A copy of the agreement must be on file with the lead agency to ensure adequate planning for peer review site visits.

The Southwest/Piedmont HIV Care Consortium has agreed to cover mental health therapy/counseling as follows:

1. Subcontractors must use the **most cost-effective services** such as local community service boards before using Ryan White funds for substance abuse services. Documentation must be in the client's chart that other resources were first sought and were unable to meet their needs.
2. **Referrals:** A referral from the infectious disease physician is necessary before Ryan White funds can be used. Ryan White is the payer of last resort.

Unit of Service: 1 visit

Capitation: The cost per unit of Service is:

Exclusions: The following services are not covered with Ryan White Part B funds:

- Inpatient mental health treatment

Service Limits: The following limits have been placed on Substance Abuse services:

- Providers must develop a treatment plan after the third visit with goals and objectives

SUPPORT SERVICES

Case Management (Non-Medical): Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

The Southwest/Piedmont HIV Care Consortium has agreed to cover client advocacy as follows:

1. **Standards:** All subcontractors must comply with the Virginia Department of Health Case Management Standards as revised January 15, 2008.
2. **Levels of Case Management:** Non-medical case management may be provided to clients who have documented needs for Supportive or Limited levels of service as described within the VDH Case Management Standards. Non-medical case management MAY NOT be use to provide Comprehensive level of service as described within the VDH Case Management Standards.
3. **Assignment of Cases:** Clients are to be assigned to ONE and only one case manager at ONE and only one service level (Supportive or Limited). The assigned case manager is the primary service provider for that client. From time to time it is understood that for reasons of staffing (vacations, sick leave, field work, etc.) the primary case manager is not available to assist the client with necessary work. Other agency case managers may pitch in to assist the client and then report what was done to the assigned case manager in the most appropriate and expedient method.
4. **Eligibility:** Initial and annual eligibility services MUST be conducted by and identified case manager in order to be reported under Limited case management. Use of any other employee renders eligibility an administrative activity and must then be conducted with administrative or in-kind funds.
5. **Personnel:** All subcontractors must notify the lead agency in writing of the hiring, separation or termination of a person employed as a case manager.
6. **Background Checks:** It is highly advisable for all subcontractors to conduct Virginia State Police and Department of Motor Vehicles background checks on all case managers under their employment.
7. **Travel:** Under the category of case management, travel expenses are allowed as a service fee with the following restrictions:
 - Travel must be used to carry out face-to-face visits with clients or for such activities that carry out the client's plan of care.
 - Travel may not be used for hospital visits.
 - It may not be used to transport clients.
 - Travel may not be used for meetings, conferences and trainings.

Unit of Service: 15 minute segment of time, face to face, non-face to face or other.

Capitation: NA

Exclusions:

- May not be used for case finding activities (See Outreach/Referral to Services)
- May not be used for Treatment Adherence activities

Service Limits:

- Mileage reimbursement may not exceed current state rate.
- Clients receiving non-medical case management services may not be enrolled simultaneously in medical case management.

SUPPORT SERVICES

Medical transportation services: Include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Notice: Travel for case managers to and from client “face-to-face” contacts may not be billed under this category. Travel is a separate services fee charged under case management.

The Southwest/Piedmont HIV Care Consortium has agreed to cover transportation as follows:

1. Transportation to and from Ryan White approved core medical services is covered for clients without Medicaid or no other means of transportation.
2. **Justification for transports:** Clients must have a recognizable need for transportation services such as being unable or unsafe to drive, not having access to a vehicle or having a vehicle that is unsafe to drive, including the issue of likely breakdowns. All such issues are to be documented in the patient’s chart.
3. All other means of transportation should be explored before using Ryan White Funds and any exceptions should be documented on the client’s chart.
4. **Distance Policy:** Subcontractors are not required to transport a client further than the nearest qualified and available provider or other such distance that is deemed reasonable. The provider must be able to enroll the client in service(s), otherwise the subcontractor would have to pay for the distance to the next qualified provider.
5. **Multiple Client Transport:** It is highly recommended that subcontractors arrange to transport more than one client at a time to medical appointments.
6. **Wait Time:** Wait time may be charged by drivers should be approved on a case by case basis.
7. Clients and direct family members may not be reimbursed for their own mileage.
8. **No Shows:** Mileage reimbursement for drivers who attempt to pick up clients for scheduled transports must be paid if the client is a no-show.
9. **Background Checks:** It is highly advisable for all subcontractors to conduct Virginia State Police and Department of Motor Vehicles background checks on all drivers (employed or volunteer)..

Unit of Service: 1 mile.

Capitation:

- Mileage reimbursement may not exceed current state rate.
- Charges for wait time may not exceed \$5.50 per hour.

Exclusions: Subcontractor employees are not eligible for wait time.

Service Limits:

- Case managers should not be used as drivers to transport clients unless there are no other options or the transport is an emergency. Any requests for exception, must be in writing with the lead agency.