Guide to Requirements for Service Payability and Data Reporting In NYC DOHMH Performance-Based Contracts For HIV Care and Prevention Administered by Public Health Solutions

April 2017

Contents

I. Purpose and Scope of This Guide

This guide is designed to bring together in a single place the most pertinent information about the services, data reporting requirements and payment rules in performance-based contract categories

This guide provides additional clarification to payment rules mentioned in contractors' individual Scope of Services. When this guide is in conflict with a contractor's individual scope of services, this guide will prevail, except when the scope of service explicitly exempts the contract from a service category's usual requirements. A contractor who feels that their scope of service is inconsistent with this guide should contact their contract manager for clarification.

Within each service category, this guide generally includes two subsections:

- First, there is a table listing all of the service families and each service type within each family. For each service type, the table provides the PHS Code (used on the Master Itemization Report) that represents the type.
- Second, there are payability rules that apply to particular service families or service types within the category; these contain a great deal of information relevant to payment processing, recoupment and compliance.

II. History of Changes

This guide is updated approximately quarterly to reflect ongoing changes in the performance-based service categories, the rules for reporting their data, and PHS' payment procedures. The table below shows, in reverse chronological order, a history of the changes in each version:

Version Date	Significant Changes
April 2017	• New sections have been added for the Ryan White service categories: o Health Education and Risk Reduction (HER) o Harm Reduction Services (HRM) o Mental Health Services (MHV) • In the Demonstration Projects (DEM) service category, a rule has been removed: o Referrals (Code 470) of the same type are now payable more than once. • In the Supportive Counseling (SCG, SCI, SCP) categories, two new service types have been added: o Seeking Safety – Individual (Code P61) o Seeking Safety – Group (Code Q14)
March 2016	• In the Sexual and Behavioral Health (SBH) service category, the following changes have been made: o New service types have been added: ▪ PEP Prescription – Medical (Code N16) ▪ PEP Prescription – Non-Medical (Code N17) ▪ PEP Follow up – Weekly (Code N18) ▪ PrEP/PEP Combination Prevention Education (Code N19) ▪ PEP Starter Packs (Code N20) o Rules have been added: ▪ A PEP Follow-up – Weekly (Code N18) must occur no more than 28 days after an initial medical visit (Code N05 or N06) in order to be processed for payment. ▪ No more than three PEP Follow Up – Weekly (Code N18) visits are payable after each PEP initial medical visit (Code N05 or N06). o A new rule has been added effective January 1, 2016: the Linkage to Social Services (Code P69) is only payable if its disposition is one of the following three: Completed; Refused or cancelled by agency staff; Client showed but appointment not completed, not rescheduled. o A new rule has been added effective January 1, 2016: PEP Follow Up – 30 Day (Code N07) and 90 Day (Code N08) visits are not payable unless there is an HIV test on the same day as the medical visit. o The service families to which service types belong have been reorganized. • A new rule has been added for all service categories that perform HIV testing: An HIV test (Code 218) is not payable if the client also has, on the same day, a PEP or PrEP initial medical visit, or a PEP follow up visit (Code N05, N06, N07, N08, N09), under a Sexual and Behavioral Health (SBH) contract. • In the Enhanced Condom Distribution Services (CON) service category, a rule has been added: Services are only payable if they occur at venues within zip codes specified in their contract scope documents. • In the Community Level Interventions (CLI) service category, a new service has been added: D-Up Training Session 01-B (Code EYO). In order to be payable, this service must have at least 3 participants and no more than 15 participants, and must last a minimum of 90 minutes. Completion of this service is a required component of the D-Up Peer Training Completion payment point (Code 0EY).
September 2015	• New sections have been added for the Ryan White service categories Supportive Counseling and

	Family Stabilization (SCG / SCI / SCP) and General Non-Medical Case Management (NMG). • In the Legal Services (ADV) service category, the list of permitted case types has been revised. Effective March 1, 2015, Immigration cases are now allowed for the purpose of obtaining PRUCOL (Permanent Residence Under Color of Law) status in connection with access to public benefits. • A new rule, effective July 1, has been added for all Ryan White service categories which report the service type Reassessment (Code 076) based on the eSHARE service type detail 'Reassessment (clinical, psychosocial, general health/well-being, housing, enrollments, etc.)', whether for performance-based payment or for compliance purposes. This service will not be recognized unless both an Individual Services Delivered form and a Reassessment form have been entered in eSHARE, with the service date on the former having the same date as the Date of Reassessment on the latter. • In the Sexual and Behavioral Health (SBH) service category, the following changes have been made: o Several service types formerly having names beginning with NPEP have been renamed to begin with PEP (Post-Exposure Prophylaxis). o Effective July 1, 2015, a new service family called PrEP Services has been created. It includes six new service types related to Pre-Exposure Prophylaxis (PrEP). o For the new service type PrEP Initial Medical Visit (Code N09), rules have been added: Payment will not be processed unless there is an STI screening service within the period between twenty-eight days before and fourteen days after the date of the initial medical visit. Medical visits are not payable unless there is an HIV test on the same day as the medical visit. o For the service type Rapid Test (Code 218), a rule has been modified: A test will not be processed for payment if there is a PEP initial medical visit (Code N05 or N06) or a PrEP initial medical visit (Code N09) on the same date. o For the service type STI Syphilis/Gonorrhea/Chlamydia Screening (Code P65), a rule has been modified: an STI screening will not be processed for payment if it occurs during the period between four days before and fourteen days after the client had a PEP Initial Medical Visit (Code N05 or N06), or if it occurs during the period between twenty-eight days before and fourteen days after the client had a PrEP initial medical visit (Code N09). o Effective July 1, a new service type called Benefit Navigation (Code 470) has been added. o Effective September 1, a new service type Vaccination (Code N15) has been added. The previously existing service type Hepatitis A and B Vaccine (Code P68) has been eliminated. o For the new Vaccination service type (Code N15), a rule has been added: A vaccination service for Hepatitis A (Alone), or for Hepatitis B (Alone), is not payable if the client also has a TwinRex vaccination on the same date. • In the Outreach to Homeless Youth (OHY) service category, the following new rules have been added: o Coordination with Service Providers (Code P29) is only payable for clients who are HIV+. o Readiness for Primary Care Counseling – Group (Code P18) services are only payable if they have at least three Ryan White participants. In the situation of only one or two participants arriving for a scheduled group service, a service provider may provide each client with a separate individual counseling session. Providing a joint service to two participants and reporting it as two individual services is not permitted. o Readiness for Primary Care Counseling – Family (Code P17) services are only payable if they have at least two participants. • In the Intravenous Drug Use (IDU) service category, a new rule has been added for the service type Targeted Case Finding (Code 545): Each event must be reported as a single record, which must include the complete count of persons contacted and/or engaged.
April 2015	• In the Harm Reduction (HRR) and Mental Health (MSV) service categories, several types of group services have had their unit of reimbursement changed from the session to the attendee. For all of these group service types, a maximum of six attendees are payable per session. In order for attendees in these groups to be payable, the total size of the group must be at least three clients (including both those paid by Ryan White and those paid by other funding sources). The group service types affected are: o Group Counseling – AOD (Code P87 – formerly Code 038) o Group Counseling – Low Threshold AOD (Code P90 – formerly Code 253) o Group Counseling – Mental Health (Code P88 – formerly Code 039)

	○ Group Counseling – Treatment Adherence (Code P89 – formerly Code 238) • In the Harm Reduction (HRR) and Mental Health (MSV) service category, a new service type has been added: Biomedical Counseling – Partners (Code P86). • In the Mental Health (MSV) service category, two new service types, Outreach for Client Reengagement – Home (Code H01) and Outreach for Client Reengagement – Office (Code H02), have replaced the previous service type Outreach for Client Reengagement (Code P56). • In the Outreach for Homeless Youth (OHY) service category, the following changes have been implemented: ○ A rule has been clarified: Negative clients must be closed out after the end of a 12 month period. If they continue to be high risk, they may be re-opened for another 12 month period. ○ The payment point service "Referral for HIV Testing" (Code 080) has been discontinued. ○ A new rule has been added: Services are not payable more than 90 days after the client has had a Linkage to Care (Code P25, P26 or P27) under the OHY program or any other DOHMH-funded program in the same agency. ○ A new rule has been added: Testing Readiness sessions (Code P15) are not payable for clients having a positive HIV status prior to the date of service. ○ A new rule has been added: Readiness for Primary Care individual and family counseling (Codes P16, P17) are not payable if the client does not have a positive HIV status on the date of service. ○ A new rule has been added: Referrals for Housing and Supportive Services (Code P20) are only payable for clients having a negative HIV status, not for clients whose status is still unknown. ○ A rule has been changed: A maximum of three Referrals for Housing and Supportive Services (P20) are payable following each HIV test. (The previous limit was three during a twelve-month period.) • In the Care Coordination (MCM/MCC) service category, another encounter type has been added to the list of those which count as "face-to-face" for the purpose of reaching payability thresholds: Health Education – Group. • In the Sexual and Behavioral Health (SBH) service category, a new rule has been added, effective May 1, 2015: an NPEP Initial Medical Visit, with or without PAP (Code N05 or N06), is not payable unless there is an HIV test on the same day as the medical visit. • In the Client-Level Intervention (CLI) service category, the following changes have been implemented: ○ Two service types have been discontinued: Community PROMISE Anonymous Contacts (Code EYH) and Community PROMISE Stage-Based Encounters (Code EYJ). ○ Two new service types have been added: Community PROMISE Role Model Story Distribution (Code EYM) and Community PROMISE Conversations in the Community (Code EYN). ○ A new rule has been added. For D-Up Conversations in the Community (Code EYG) and Popular Opinion Leader Conversations in the Community (Code ENA), payment will not be processed unless the event occurred at one of the venue types listed in the instructions that have been distributed by DOHMH. ○ A previously announced rule has been noted: In order for a D-Up Client Completion (Code 0EY) or Popular Opinion Leader Client Completion (Code 0EN) to be processed for payment, all requirements must be completed within 90 days.
February 2015	• A new rule has been added in all categories that perform HIV Tests (Code 218). Any test that is reported for the same client on the same day in more than one of an agency's contracts will have both records (under both contracts) marked for recoupment. It is the responsibility of the agency to review marked records, determine which contract actually provided the test, and correct the reporting. • In the Care Coordination (MCM/MCC) service categories, non-ART DOT (Codes P63 and P64) is no longer a distinctly named payment point. All forms of directly observed therapy, including both ART and non-ART, will be recognized using the same payment point (Codes M31 and M32). • In the Client-Level Intervention (CLI) service category, a new rule has been added. For D-Up Client Completion (Code 0EY) and Popular Opinion Leader Client Completion (Code 0EN), each client must complete and submit a D-Up/POL attribution form (through SurveyMonkey) prior to the completion of the training cycle.

	• In the Sexual and Behavioral Health (SBH) service category, the list of payment point services and rules applicable to them has been updated to reflect changes in the new contract year: o A previous service type has been split into two new ones: STI Gonorrhea/Chlamydia Treatment (Code P97) and STI Syphilis Treatment (Code P98). o A previous service type has been split into two new ones: NPEP Follow Up – 30 Days (Code N07) and NPEP Follow Up – 90 Days (Code N08). o The wording of several existing rules has been adjusted to reflect the reconfigurations of service types described above. o A previous service type has been renamed to be Hepatitis B and C Screening (Code P67). o Two new service types have been added, with associated rules: ▪ Hepatitis C RNA Testing (Code P99). Only one Hepatitis C RNA Testing is payable per client per contract year. ▪ Mental Health/Substance Use Screening, Brief Intervention & Referral to Treatment (Code P96). In order to be processed for payment, the record must show that all four screenings (PHQ9, GAD, DAST and AUDIT) have been completed. The record must also show that the client either received or refused the brief intervention for mental health or substance use. o A rule has been changed: Payment for an NPEP Initial Medical Visit, with or without PAP (Code N05 or N06), will not be processed unless there is an STI screening service within the period between four days before and fourteen days after the date of the initial medical visit.
September 2014	• New sections have been added for the Prevention service categories Enhanced Condom Distribution (CON), Sexual and Behavioral Health (SBH), Community-Level Interventions (CLI) and Demonstration Projects (DEM). • The Housing Placement (HPA/HPC) service category has been revised to reflect changes in the payment points beginning in March 2014 when new contracts began. • In the Intravenous Drug Use (IDU) category, a new payment point service has been added: Targeted Case Finding (Code 545). It has the following rule: In order to be payable, a Targeted Case Finding event must have at least 10 persons contacted OR 3 engagements with potential clients. • In the Transitional Care Coordination (TCC) service category, two new payment point services with associated rules have been added: o Intake and Assessment (Code 115). Only one Intake and Assessment service is payable for each client enrollment period. o Reassessment (Code 076). Only four Reassessment services are payable within a 365-day period. • In the Food and Nutrition (FNS) service category, payment point services and associated rules have been revised as follows: o The Screening and Comprehensive Treatment Plan (Code 225) payment point, which was previously constructed based on two services, has now been split into two separate payment points: Intake and Assessment (Code 115) and Comprehensive Care Plan Development (still Code 225). Each of the two service types may only be provided once per client per enrollment. o The Reassessment and Comprehensive Treatment Plan Update (Code 226) payment point, which was previously constructed based on two services, has now been split into two separate payment points: Reassessment (Code 076) and Comprehensive Care Plan Update (still Code 226). Each of the two service types may only be provided three times per client in a twelve-month period. • In the Outreach to Homeless Youth (OHY) service category, a new payment point service has been added: Coordination with Service Providers (Code P29). • New rules have been added in the Outreach to Homeless Youth (OHY) service category o Services provided to HIV-negative clients more than twelve months after program enrollment are not payable. o Services provided to HIV-positive clients more than eighteen months after program enrollment are usually not payable. However, service providers may request a waiver from Public Health Solutions (subject to DOHMH approval) to provide services in excess of 18 consecutive months for positives not yet linked to care. Waivers will be reviewed on a case by case basis. • In the Mental Health (MSV) service category, the required credentials for supervision of services

	provided under the mental health service family have been revised. • In HIV Testing categories using the Social Network Strategy (SNS/EIN/ESN), a rule has been changed. Within 12 months of the initial Rapid Test (Code 218), a recruiter or network associate may be re-tested one time. Otherwise, subsequent testing of the same client is only payable if the client was referred by a different network recruiter. • In all HIV Testing categories, a previously existing rule has been noted: A Linkage Navigation (Code P28) will not be processed for payment unless the client has an earlier confirmatory test under the same Form ID.
December 2013	• In the Transitional Care Coordination (TCC) service category, criteria for achieving Graduation (Code P24) have been changed. o Graduation now requires that the client have been enrolled continuously (without disenrollment/reenrollment) for at least nine months. (The previous criterion was twelve months.) o The requirement that the client be linked to care may be satisfied by either a Linkage to Care (Code P27) or a linkage via the work of another case management agency. The latter option must be indicated in eSHARE as a Coordination with Service Providers with details specifying Primary Care and Verification. • In the Food and Nutrition (FNS) service category, a rule has been revised. For the Reassessment and Comprehensive Treatment Plan Update (Code 226), only three reassessments per client are payable within a twelve-month period. (Previously the limit was two.) • In the Food and Nutrition (FNS) service category, the previous rule that "No more than seven pantry bag meals per index client are payable per week" has been removed. An overall rule remains in force: no more than fourteen meals of all three types together per index client are payable per week. • In all service categories that do HIV testing, a new rule has been added: a Confirmatory Test (Code 333) is not payable if it is performed using rapid test technology. • In all service categories that do HIV testing, two new rules have been added for the Linkage Navigation (Code P28) payment point: o A Linkage Navigation is not payable if its date is more than 365 days after the original Rapid Test. o A Linkage Navigation is not payable if the same client has a Linkage to Care – Known Positive (Code P27) within 365 days after the original Rapid Test. • In the service categories that perform testing using the Social Network Strategy in Non-Clinical Settings (EIN, ESN, SNS), a previously announced payment point for Recruiter Coaching (Code P54) has been added to the Guide. • In the service categories that perform testing using the Social Network Strategy in Non-Clinical Settings (EIN, ESN, SNS), a rule has been added for Recruiter Coaching (Code P54): For each recruiter, only seven Recruiter Coaching sessions are payable for the life of the contract. • In the Harm Reduction (HRR) service category, for services in the Evidence-Based Intervention service family, the multipliers used in conjunction with payment rates have been adjusted to reflect the time and effort involved. • In the Care Coordination (MCM/MCC) service category, a number of previously announced rules have been added to the Guide. They affect which services count as face-to-face for the purpose of reaching payment thresholds. For the "Assistance with…" service types, the service detail must not be "Court Advocacy"; for the "Care plan/service plan" service type, the service detail must not be "Housing services plan" or "Discharge plan"; and for the "Other assessment/reassessment" service type, the service detail must not be "Adherence assessment – other measure", "Health assessment", "Client risk assessment", "Mental health", "Harm reduction", "Case management", "Nutritional assessment" or "90-day follow up". • In the Legal Services (ADV) service category, restrictions previously announced elsewhere have been added to the Guide. Case types that are not payable by Ryan White include: Divorce, Family Violence, Citizenship/immigration status, Criminal defense proceedings, and Class-action suits unrelated to access to services eligible for funding under the Ryan White program.
May 2013	• A new service category section has been added: Intravenous Drug Use (IDU). • In all service categories that do HIV testing, a rule has been changed: Only one confirmatory test per client is payable, with the exception of situations where a second test is necessary because the first test was (a) indeterminate; (b) negative and an OraSure HIV-1 western blot; or (c) invalid.

	• In the Care Coordination (MCM/MCC) category, two new payment point services have been added: Non-ART DOT Visit at Client Home (Code P63) and Non-ART DOT Visit at in Clinic (Code P64). • In the Care Coordination (MCM/MCC) category, a previously announced rule has been added to the Guide: For the "Health education / promotion" service type, topics under the rubric of "Non-Care Coordination health education conversations…" do not count toward the required thresholds of service. • In the Supportive Counseling and Family Stabilization (SCF) category, a new payment point service has been added: Accompaniment (Code 030). • In the Harm Reduction (HRR) category, two payment point services have been eliminated: Assessment for STI (Code 241) and Substance Use Assessment (Code 269). • In the Harm Reduction (HRR) category, there are three new payment point services: Intake Assessment (Code 115), Reassessment (Code 076) and Auricular Acupuncture (Code 286). • In the Harm Reduction (HRR) category, a rule has been added: the new payment point service Auricular Acupuncture has a frequency limit of twelve per month per client. • The Harm Reduction (HRR) payment point EBI Individual – Long (Code P34) has been replaced by the payment points Seeking Safety – EBI – Long (Code P61) and Healthy Living – EBI – Long (Code P62). • In the Harm Reduction (HRR) service category, the following rules have been added: o For each client, only one Seeking Safety – EBI – Long (Code P61) per day is payable. o For each client, only one Healthy Living – EBI – Long (Code P62) per day is payable. o For each client, only one EBI Medium (Code P32) service per day is payable. o For a client who receives a Seeking Safety – EBI – Long (Code P61), an EBI Medium (Code P32) on the same day is not payable. o An EBI Group Session (Code P35) is only payable if at least three participants attend. • In the Mental Health (MSV) service category, a new service family called Mental Health Advocacy has been added. It includes five new payment point services: Accompaniment (Code 030); Client Engagement Activities (Code P55); Outreach for Client Reengagement (Code P56); Wellness Group (Code P58); Wellness Individual Session (Code P57). • In the Mental Health (MSV) service category, the previous rule which limited Home Visits for Clinical Purposes (Code 251) to four per year per client has been removed. Please note, however, that Home Visits for Clinical Purposes still count toward the overall limit of ten mental health services per month per client. • In the Transitional Care Coordination (TCC) service category, requirements for the Graduation (Code P24) payment point have changed. Graduation will be credited when the client has been enrolled continuously (without disenrollment /reenrollment) for at least twelve months and has received the following services: o Linkage to Housing Services (P23) o Linkage to Primary Care (P27) o Transfer to Case Management Program (P45) o Health Promotion (P22) sessions on at least six different topics Only one Graduation is payable for each client enrollment period. • In the Transitional Care Coordination (TCC) service category, a rule has been added: the Transfer to Case Management service (Code P45) is payable only once per client enrollment. • In the Outreach to Homeless Youth (OHY) service category, a rule has been added: payment for Psychosocial and Client Risk Assessment (Code P21 will only be processed for clients who are HIV+. • In the Outreach to Homeless Youth (OHY) service category, a rule has been changed: A maximum of three Referrals for Housing and Supportive Services for HIV- individuals (Code P20) are payable during a twelve month period. • In the Outreach to Homeless Youth (OHY) service category, a rule has been changed. Rapid Tests (Code 218) and Referrals for HIV Testing (Code 080) are payable for each client four times per contract year. (Previously the rule was four times per twelve-month period.) • In the Food and Nutrition Services (FNS) service category, a rule has been changed: Only one

	Comprehensive Nutritional Assessment (Code 035) per client is payable within an enrollment period.
February 2013	• Information on HIV Testing contracts is now contained in a new section that spans Ryan White and Prevention funding sources. • New sections have been added for the Transitional Care Coordination (TCC), Outreach to Homeless Youth (OHY) and Food and Nutrition Services (FNS) service categories. • In the Supportive Counseling and Family Services (SCF) category, the Care Coordination – Phone and Follow up – Phone service types have been folded into the Care Coordination – Office and Follow up – Office service types. • The SCF Category has been revised to include the following requirement: The program will provide services to collaterals (family members/significant others) of HIV+ persons (index clients). Services provided to a collateral of HIV+ persons (index client) can only take place in conjunction with the HIV+ person except where the index client has died and the collateral(s) receives individual and/or family bereavement counseling (only up to 90 days of services). The collateral(s) can be HIV-positive or HIV-negative. • In the Harm Reduction (HRR) and Mental Health (MSV) categories, service types and service rules have been revised to reflect the fact that services to persons who are known to be HIV negative are not billable, except for attendance at family sessions with an HIV+ index client. • The Harm Reduction (HRR) category has been revised to reflect the set of service types for HIV testing and linkage to care which are based on eSHARE's testing module. • The Harm Reduction (HRR) category has new service types for evidence-based interventions. • In the Mental Health (MSV) category, a rule has been changed. The Care Coordination with Primary Care Provider is payable once every 90 days, rather than once every four months. • The Care Coordination category section has been revised to incorporate the rules regarding minimum thresholds of service required to validate Per-Member-Per-Day enrollment; and to reflect the elimination of milestone services. • The Cofactors (COF) category section has been revised to describe payment processing requirements for services entered in eSHARE (since March 2012). • In the Cofactors category, eight new service types have been added. • In the Cofactors category, a previous rule has been removed. Clients who self-report currently receiving mental health treatment are still eligible for Mental Health Screening, and clients who self-report currently receiving substance use treatment are still eligible for Substance Use Screening. • In the Evidence-Based Interventions (EBI) category, in the Healthy Relationships – 1 intervention, the rule regarding full program client services has been changed. The rule is now that a client's attendance may be counted toward the payability of one of each of the five numbered sessions, and toward one introductory session and one booster session.
July 2011	• The Care Coordination section clarifies the process of calculating payment based on data from eSHARE: in instances where a client has more than one Intake Assessment and/or Patient Status Change form referring to the same intervention track enrollment date, Public Health Solutions' payment system will use the information (track and reason for change) contained in the last form created; information in forms created earlier on that date will be disregarded. • For all service categories that do HIV Testing, references to recording NAAT confirmatory tests in a separate Excel spreadsheet have been removed. Documentation provided by Data Link includes information about changes in AIRS version 8.7 which now permit NAAT confirmatory tests to be entered after a negative Rapid Test. • In the Evidence-Based Intervention section, the introduction has been updated to provide information about circumstances in which group sessions which do not meet requirements for payability may, nonetheless, count toward the participants' requirements for client completion. • The Co-factors section has been updated with information about new rules for data entry in AIRS which may affect payment: o A Substance Use Brief Intervention (P08) must have, attached to the encounter record, a referral to substance use treatment. (The Substance Use Screening which precedes the Substance Use Brief Intervention should not have that referral attached to it.) o The Linkage to Testing (P04) payment point is created by attaching a a referral for HIV testing to an encounter representing one of the four co-factor screens (Substance Use, Mental Health,

	STI-Blood or STI-Urine). The referral to HIV testing should not be attached to a Substance Use Brief Intervention; doing so will not create a Linkage to Testing payment point. o The new version 8.7 of AIRS contains a number of new test codes. Nonetheless, service providers should continue to enter test types and values following the Co-factors data entry instructions provided by Public Health Solutions. For STI-Blood encounters, AIRS will automatically create a lab test with type 'SY' for Syphilis. Service providers, however, should continue to use the code '98' in that situation. That will require manually changing the 'SY' to '98'.
March 2011	• The section for Care Coordination has been updated to reflect the new Medical Case Management reimbursement model beginning on March 1, 2011. • In the Care Coordination section, the Outpatient Bridge Care component has a new payment point, OBMC Patient Navigator Visit. Rules regarding the Outpatient Bridge Care component have been revised to state: "For each client, Outpatient Bridge Medical Care is payable only two times per calendar month and OBMC Patient Navigator Visits are payable only two times per calendar month." • The Cofactors category has a new payment point, Substance Use Brief Intervention, effective March 1. • A rule in the Evidence-Based Intervention Popular Opinion Leader (Internet-Based) has been changed: a client's attendance may be counted toward the payability of one of each of the four numbered group sessions, and up to seven (rather than four) additional group sessions. • In the Rapid Testing in High-Risk Venues (RTV) category, rules have been changed. The STI Screening – Blood and the STI Screening – Urine may each be provided twice (rather than once) in a 365 day period. • The section for the Legal Services category now states: Services by volunteers or interns must be entered under their names, not under the name of the supervising attorney. Services must be entered in a way that indicates the actual begin and end times when that they were provided. • In the section for the Cofactors category, the DAST-AUDIT instrument has replaced the CAGE-AID.
November 2010	• Sections for all contract categories that perform HIV testing have been revised because of changes in the AIRS CTR module: o For reporting NAAT confirmatory tests and the linkages to care based upon them, because the version of AIRS released in the summer of 2010 does not permit entry of a confirmatory test after a negative rapid test, users must now record provision of NAAT tests outside of AIRS using an Excel spreadsheet log provided by Public Health Solutions. o The new CTR module only permits two tests to be entered. When an oral rapid test has a preliminary positive result and the provider performs a follow-up rapid test using fingerstick blood, the provider should <u>not</u> enter the second rapid test into AIRS. Instead, the provider should enter the first rapid test and the eventual confirmatory test into AIRS. The second rapid test must be recorded outside of AIRS using an Excel spreadsheet log provided by Public Health Solutions. • Beginning in August 2010, in the Early Intervention and Harm Reduction categories, a linkage to care for a known positive client who did <u>not</u> receive a confirmatory test (Code 079) must be attached to a referral record verifying the client's attendance at their first appointment with their primary care provider. Linkages lacking this referral record will not be processed for payment. See the category sections for revised data entry details. • Service providers in the Early Intervention category have a new payment point service: Confirmatory Test. • Service providers in the Early Intervention and Harm Reduction categories that are implementing the social networking model have a new payment point service, Recruiter Cost, effective retroactive to May 2010. • In the Harm Reduction category, a rule has been added stating that the Low Threshold Substance Use and STI screenings (codes P05 and P06) are payable only once per client per contract year. • For contracts in the Care Coordination category that provide Outpatient Bridge Medical Care (code 784), two rules have been changed, retroactive to March 1, 2010: These services may be provided to each client up to four (rather than two) times per month for eight (rather than four) distinct calendar months. • For group services in the Mental Health, Harm Reduction and Supportive Counseling categories, a rule has been clarified: In the situation of only one or two participants arriving for a scheduled group service, a service provider may provide each client with a separate individual counseling session. Providing a joint service to two participants and reporting it as two individual services is <u>not</u>

	permitted. • In the Mental Health category, language has been added to state that MSWs with a limited permit to practice licensed clinical social work are allowed to provide mental health services under the supervision of an LCSW. • A rule in the Evidence-Based Intervention Safety Counts has been changed. For each client, up to eight (rather than four) individual encounters are payable. • Section III-A states the DOHMH policy on data entry. • Requirements for reporting Primary Care Status Measures have been updated. • The description of the Master Itemization Report in Section III-D has been updated. The MIR now includes a Summary of Issues Noted section.
August 2010	• In the introduction to the Legal Services category, the lists of case types that are allowed, conditionally allowed or not allowed have been changed. The changes are effective retroactive to April 8, 2010. • In the Care Coordination service category, a new service has been added: Baseline OBMC Labs. • In the Care Coordination service category, rules for outpatient bridge medical services were expanded to state that services may be provided to each client for four distinct calendar months. Following that period, outpatient bridge care services will be invalid unless specifically authorized for that client by the NYC Department of Health and Mental Hygiene. • In the Harm Reduction category, Confirmatory Test and Linkage to Care have been added as new payment point services**.** • In the Early Intervention service category, a requirement was edited to state "Staff must work with all HIV positive clients to ensure attendance at first appointment with HIV primary care provider." Language referring to attendance at the second appointment was removed. • In the Early Intervention and Harm Reduction categories, instructions about the two data entry methods for entering Linkages to Care have been clarified. For each client who is linked to care, only one of the two methods should be chosen. The determining factor for choosing a data entry method is whether or not the client has received a confirmatory test (not whether or not the client's status was previously known). • In the Evidence- or Theory-Based Interventions category, a new subsection was added for the Willow intervention. • The Maintenance in Care service category was removed. • The Housing Legal Services category was removed.
May 2010	• The section on the Master Itemization Report (MIR) was edited to reflect the fact that the report now includes projections. • A new section was added for the Evidence or Theory-Based Interventions (EBI) service category. Only those interventions which are paid performance-based are included. • Early Intervention and Harm Reduction sections were updated to state revised rule that each client may receive up to four Rapid Tests per contract year. • Sections on service categories that have Confirmatory Test and/or Linkage to Care payment points were updated to note that for acutely infected clients, these services are payable based on the reporting of a NAAT positive result from a confirmatory test that follows a negative rapid test. (See details for data entry procedure.) • Sections on all service categories that have Linkage to Care payment points were updated to clarify the data entry procedure involving the CTR module and the referral to a primary care provider. • The Early Intervention section was updated to state that eligibility for linkage to care includes clients who have been out of care for nine or more months in addition to those who have never been in care. • The Early Intervention section was updated regarding Linkages to Care. The different data entry procedures (depending on whether the linkage to care was for a known positive client or for one identified through testing) were clarified. There are also now two different service type codes on the MIR corresponding to these two situations; previously both situations were subsumed under the same service type code. • The Early Intervention and Harm Reduction sections were updated to state that Rapid Tests that do not have a test result entered will not be processed for payment. This change was communicated to

	contractors in a letter from Public Health Solutions on March 11, 2010. • The Harm Reduction section was updated to include two new payment point services among the Low Threshold AOD Services. These are Low threshold Assessment and Referral for STI and Low threshold Screening and Referral for substance use treatment. They are substantively the same services as are already provided under the AOD Services family, but now may be provided to HIV- clients. • The Harm Reduction section was updated to state that Overdose prevention services that do not involve dispensing Narcan may be billed as normal Individual or Group AOD Counseling. • The Care Coordination section includes the new rules that: Enrollment records which are redundant (i.e. which merely repeat a client's enrollment in the same track, which was already reported on a previous date) will be marked for deletion and must be removed from AIRS by the contractor; and any instances in which the same client has more than one Enrollment record of different types on the same day will be marked for review and correction by the contractor. • The Care Coordination section mentions that there are a number of AIRS encounter/service mappings that are not currently tracked by Public Health Solutions, and are therefore not listed in this guide, but which must be entered if those services are provided. They are in the AIRS master mapping table as "Primary Medical Care 7 Tier" service category with encounter code 165 and encounter name "Routine Visit (7 Tier)". They represent specific medical services that may be provided in conjunction with the Outpatient Bridge Care service (784).
January 2010	• Section on site visit review of data was updated to mention that items marked for certain kinds of review (e.g. possible duplicates) may be reviewed by PHS staff during site visits and then validated in the PHS payment system on that basis. Reasons used in that situation were added to the list. • Legal Services section mentions that unusually long legal services will be automatically marked for review. • Rapid Testing in Social Networks section was updated to state rule that a second rapid test for the same client is only payable if the client was referred by a different network recruiter; such tests will be marked for review. • All Prevention category sections are updated to state rule that a confirmatory test that does not have a previous rapid test with a reactive result will be automatically marked for data entry correction or recoupment. • New service category sections were added for Care Coordination, Rapid Testing in High-Risk Venues and Housing Legal Services.
October 2009	• Data submission section was updated to include diagram showing data flows from service providers' AIRS installation to PHS. • Legal Services section was updated to reflect HRSA limitations on types of cases, as communicated to service providers through a letter from PHS on September 1, 2009. • Co-factors sub-sections on Rapid HIV Test and Linkage to Testing were updated to clarify the requirement—and the data entry procedure for tracking—that client must have had a positive cofactors screen within previous 90 days. • Rapid Testing in Social Networks section was updated to remove Incidence Diagnosis service type, which as of October 2009 is no longer a payment point. • Mental Health Services section was updated to include Quick Guide to Service Frequency Limits. • In Mental Health Services section, a reference to MSWs or CASACs providing services under the mental health service family was removed. New York State regulations do not recognize these credentials as sufficient to provide mental health counseling, even under supervision.
July 2009	ORIGINAL VERSION

III. Client-Level Data Submission and Payment

A. Policy on Data Entry

The DOHMH policy on data entry for funded contracts is that agencies should report all services provided under a contract even if the reported services are above the projected target for the contract period and/or even if the reported services are not payable because they exceed client-level limitations. It is important to report all services provided for the following reasons:

- During the course of the contract year, there may be a possibility that existing client-level limitation rules might be adjusted. Such changes could render previously non-allowable services payable.
- Both during and at the end of the contract year, there may be a possibility of an opportunity for enhancement of Maximum Reimbursable Amount (MRA) based on performance. Failure to report services provided over a contract's projected targets can make the contract less likely to be eligible for this type of enhancement.
- Decisions about subsequent years' contract MRAs are influenced by past and current contract performance. Over-performance can be the basis for a permanent increase to a contract MRA.

B. Submission of Client-Level Data

The standard due date for completing data entry is close of business on the 15th of the month following the service month. For example, the data extract containing April's data is due on May 15. If the 15th falls on a weekend or holiday, then the deadline is close of business on the next business day. However, during contract closeout, the due date may be different from the usual one.

C. The Payment Process

When the PHS payment system receives data representing payment point services, the contract manager reviews the data and the status of the contract. If all prerequisites are present, the contract manager approves the payment, enters the approval into PHS payment system, and forwards it to Public Health Solutions' fiscal department so that the funds can be disbursed. Factors that can prevent a payment from being approved include, among others, a non-executed contract or renewal, lapsed insurance, non-submission of required monthly reports or an audit report.

PHS will process payment for those services that meet a basic threshold of data correctness. However, services included in payment may subsequently be assessed as non-payable, as described in the section below on Data Review and Correction/Recoupment.

D. The Master Itemization Report (MIR)

The Master Itemization Report (MIR) provides an itemized listing, as well as a summary, of the services that have been recognized as payable. It compares the summary totals with the target projections. The MIR also presents information about services recognized for payment that have been reviewed and found to be problematic.

The MIR is a cumulative report of all data received from the contract. It therefore reflects both data entry and any subsequent deletion of data.

At any given moment, the number of services recognized on the MIR may not equal the number of services that have been processed for payment; some of the services shown on the MIR may have already been paid, while others may be in the queue awaiting payment.

PHS emails the MIR monthly to the person who is designated as Program Manager on the contract. PHS simultaneously sends the Senior Administrator and Fiscal Manager a separate email alerting them that the report has been sent to the Program Manager. In the interim between the regularly distributed monthly MIR reports, an agency may request that their contract manager provide a current MIR representing data received as of that moment.

The MIR has several sections:

- Section I [DATA INCLUDED] contains information about when the MIR was run and the most recent data that affected the service count.
- Section I-A [PHS INFORMATION SYSTEM ACCOUNTING DISCREPANCIES UNDER INVESTIGATION] notes any discrepancies that may arise within PHS' payment system during the aggregation of item-level data. This section is for PHS' internal purposes only. It is usually blank. Any discrepancies that do arise will be investigated and corrected by PHS as soon as possible.
- Section II [YEAR-TO-DATE TOTALS BY SERVICE] shows, for each service type, the year-to-date total count of services, and their value, recognized by the PHS payment system, and compares them to year-to-date projections.
- Section III [SUMMARY OF ISSUES NOTED] shows a count, description and calculated value of those items which have been recognized by Public Health Solutions' payment system but are in some way problematic and will require further attention. Some such items may need to be corrected, some may need to be attested, and some may be subject to recoupment during closeout.
- Section IV [MONTH TOTALS FOR SERVICES SUBMITTED AND RECOGNIZED] shows the monthly total counts of services, and their value, recognized by the PHS payment system, and compares them to monthly projections.

- Section V [ITEMS RECOGNIZED] shows the item-level data [DC1]that informed PHS payment system. The client ID, date of service, service type and units of service are included. Items identified as problematic are shaded in color, and the nature of the problem is noted.
- Section VI [GROUP ATTENDEES RECOGNIZED] shows the individual attendees who participated in each recognized group service. It includes group services paid on a per-attendee basis and also those paid on a per-event basis. Attendee records identified as problematic are shaded in color, and the nature of the problem is noted.

E. Researching Apparent Data Discrepancies

At times, an agency may believe that it has submitted items for payment that have not been recognized by PHS. In such instances, the agency should:

1. Find specific examples of services that it believes should have been paid but do NOT appear on the MIR.
2. Verify that the examples have been properly entered in eSHARE. Please consult this Guide's sections on Payability Rules for that service type, with special attention to "Payment Processing" rules; these rules articulate the minimum threshold of data quality without which an item will not be processed for payment.
3. If the examples appear to be properly entered, send those examples via email to your PHS contract manager. The example must include date, service type and client ID (unless it is an anonymous group service).

Although eSHARE data is the basis of payment, the logic of payment resides in Public Health Solutions' information systems, not in eSHARE. Agencies are therefore requested to contact Public Health Solutions' contract managers (not the Department of Health and Mental Hygiene) about apparent payment discrepancies. If necessary, Public Health Solutions' staff will reroute questions to DOHMH staff responsible for eSHARE.

IV. The Data Review and Correction/Recoupment Processes

Some items that are processed for payment may turn out not to meet the criteria for payability. In some situations, the problem may be a data entry error that can be fixed so that the item will become payable. In other situations, the item cannot be made payable, either because it does not represent work done, or because the work that was done does not meet programmatic rules for payability.

PHS has two ways of identifying problematic items. Some are identified automatically by software routines, while others are identified by contract managers during site visits. In both cases, the problematic items will be shaded in color on the MIR and the nature of the problem will be identified in the Issue Noted column.

A. Automatic Software-Based Review

Items submitted in the data extract are reviewed automatically when they are received by PHS. Items that are duplicates (or possible duplicates) may be marked, as are items that need certain data corrections or violate certain programmatic rules. The kinds of issues reviewed differ depending on the service category. *Each service category section below has a subsection on Payability Rules that contains information on "Rules Assessed Automatically That May Make Items Recoupable".*

Note that the automatic review identifies both definite duplicates and possible duplicates.

- A *definite duplicate* means that there is more than one item of the same PHS service type for the same client on the same day, and that service type is such that no programmatic or clinical scenario could make it valid to provide more than one service. (Permanent Housing Placement would be an example.)
- A *possible duplicate* is a situation where there is more than one item of the same PHS service type for the same client on the same day, but it is programmatically possible that the second service is a valid separate service. (For example, some individual counseling service types could occur more than once on the same day.)

B. Site Visit Review by PHS Staff

PHS staff review reported items during site visits. The procedure is for the Contract Manager and/or Contract Coordinator to use a recent MIR to identify and select records for review. This list is sent to the agency prior to the site visit. During the site visit review, staff use a review tool to note any issues discovered with service tracking and documentation. At the exit interview, PHS staff discuss in detail the issues discovered and any necessary corrective actions.

The PHS staff then enters the issues discovered into the PHS payment system, attached to each specific item's record. At that point, the problematic items will show up on the MIR with their issues noted. The contract manager will keep in contact with the agency about the issues found and the actions pending.

PHS staff may also, during site visits, review items that have been automatically marked on the MIR as requiring review (e.g. possible duplicates). If those services are found to be valid, PHS staff may then validate them in the PHS payment system so that they are shown as valid on the MIR.

Below is a list of the reasons for correction, recoupment or validation that may appear on the MIR as a result of site visit findings:

Correction/Recoupment/Validation Reasons Resulting From Site Visit Findings

Reason Shown on MIR	Definition/Scope/Usage Notes
INVALID/REMOVE: No Documentation for Service Provided	No reference to service in paper or electronic progress notes, encounter forms, service log or sign-in sheet; OR there is documentation that may be meant to refer to the service submitted, but the documentation indicates a different date. (Note: For technical reasons, the date shown on the MIR for Linkage to Care services may be different from the date shown in agency documentation.)
INVALID/REMOVE: Duplicate Data Entry Error	Used when PHS needs to manually flag as definitely duplicate a record previously marked for review as possible duplicate (e.g. if PHS needs to override an agency's attestation that a possible duplicate was a separate service); OR when an otherwise duplicate record has been entered on a different date, and therefore has not been marked automatically.
INVALID: Minimum Required Data Elements Missing or Inadequate	For all services reviewed for "verification" during a site visit, specific data elements must be documented to consider the reported service verified. These data elements typically include client ID, date of service, notation of service provided, etc. If any one of these elements has not been documented, the service is flagged as recoupable.
INVALID: Extended Required Data Elements Missing or Inadequate	A sample of records reviewed for verification are also selected for an extended review to verify that all required data elements are documented. For each service type, specific data elements have been identified as necessary for verification. If any one of those elements has not been documented, the service is flagged as recoupable.
INVALID: No Documentation HIV+	No M11-Q, lab results, physician statement, etc. Applies to index clients. Applies to all services except Low Threshold (for which HIV- are permitted in first 90 days) and testing.
REMOVE & REENTER: Service Reported as Incorrect Service Type	Documentation indicates that a service provided was of a different type than entered.
MUST CORRECT BEGIN/END TIME TO AGREE WITH DOCUMENTATION	Documentation for a Direct Legal Advocacy service reviewed during site visit disagrees with begin/end time entered in eSHARE. Correction of times will result in recalculation of payment.
INVALID: Overdose Prevention Without Provision of Narcan	Documentation does not indicate that Narcan was provided or prescribed.
INVALID: Medical Outreach in SRO Requirements Not Met	Documentation does not indicate that at least 1.5 hours were spent and/or that at least one client was reached.
INVALID: Three Required Elements Not Collected/ Discussed	Documentation does not indicate that Care Coordination (PCP) included collection of elements regarding (a) appointment adherence; (b) most recent CD4 and VL; (c) HAART & prophylaxis adherence as applicable. OR documentation does not indicate that Treatment Adherence Counseling service included discussion of these elements.
INVALID: Reconstructed Documentation is Impermissible	Instances where documentation is known to have been deliberately created after the fact in order to meet contractual requirements. Includes claims found to be fraudulent.
INVALID: Payer of Last Resort Violation	For situations where there is affirmative documentation that the client had insurance, or the program had another funding source that was available to pay for the service. (Not applicable to most Prevention categories.)
INVALID: Double Billing	For services found to have been billed to other funding sources. (Applicable to both Ryan White and Prevention.)
INVALID: Lack of Required Provider Credential	For services found to have been performed by staff who did not possess the contractually required credential.
INVALID: Inadequate/ Inappropriate Service Per Service Definition	For situations where, e.g. a Mental Health service has no indication that mental health issues were discussed; a Harm Reduction rapid test with a positive result has no indication that a linkage to care was attempted.
VALID: Confirmed Separate	PHS staff have confirmed that a possible duplicate was, in fact, a separate service.
VALID: Times Verified	PHS staff have verified the times of a legal service.
VALID: Confirmed as Referral by Different Recruiter	PHS staff have verified that a second rapid test for the same client was the result of a second referral by a different recruiter.
INVALID: Deleted Client Records Still in System	PHS staff received information from a contractor and Data Link that for technical reasons, a record intended for deletion is still present in the data repository.
VALID/INVALID: Special Circumstance (See Note in Payment System)	Used for special circumstances

C. Taking Action Regarding Problematic Items

Some kinds of problematic items require that the agency take a specific action. Often, the action to be taken is mentioned in the first words of the message shown on the MIR (e.g. "REVIEW Possible Duplicate").

The basic principles of correcting data problems are as follows:

1. If an item does not represent work done for a program-eligible client, it may be marked with a message containing the word REMOVE. If the information system being used will permit removal of the item, then the item should be removed. Examples include duplicate data entry errors and instances where there is no documentation that a service took place. Removal will automatically trigger a negative adjustment in the PHS payment system. If it is not possible to remove the item, then it will be recouped during closeout.
2. If an item represents work done for a program-eligible client but does not meet the requirements for payment, it will be marked with a message that begins with the word INVALID. Examples would include violations of frequency rules, or groups with fewer than three participants. These records should NOT be removed!
3. Some items do not meet the requirements for payment but might be made payable by correcting a data entry problem. Providers should consult with their contract manager if they need further information about the possibility of fixing these.
4. Some items identified during site visits as non-payable may become payable based on the provision of further information. Providers should consult with their contract manager if they think they may have a situation of this kind. In such instances, the contract manager may later note that an item's issues have been resolved; at that point, the item will no longer be marked as problematic on the MIR.
5. Some kinds of items may require that providers make an attestation, during closeout, about the service provided. If attestations are required, specific instructions will be provided during closeout.

D. Recoupment and Holding of Payments

PHS identifies problematic payment items on an ongoing basis. Recoupment for items that cannot be corrected is calculated during closeout and added as a negative adjustment to the last payment.

However, PHS may require contractors having a high volume of data entry problems to address those problems well in advance of closeout. For example, contractors who have duplicates may be required to delete them mid-year (thereby triggering a negative adjustment in PHS' payment system). If the volume of problems grows large and a contractor fails to implement required data entry work, PHS may hold payments, pending completion of the corrections.

Toward the end of the contract year, PHS assesses the monetary value of items that are unlikely to be correctible. If the value of those items grows large, PHS may hold payments during final contract months in anticipation of the pending recoupment.

V. HIV Testing Service Categories (Ryan White or Prevention)

A. Routine Testing in Clinical Settings [EIR, ESR, HTR, HRX] and Testing Priority Populations in Non-Clinical Settings [EIP, ESP, HPT, PPT]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Rapid HIV Testing	Rapid HIV Testing	218	Individual Event
	Couples Testing	P95	Family/Group - PAID AS EVENT
Confirmatory Test	Confirmatory Test	333	Individual Event
Linkage to Care	Linkage to Care – Within 90 Days	P25	Individual Event
	Linkage Navigation [Not Yet Linked at 90 Days]	P28	Individual Event
	Linkage to Care – >90 through 365 Days	P26	Individual Event
	Linkage to Care – Known Positive	P27	Individual Event

Payability Rules

See Common Rules Section for These Services
Rapid Tests (218)
Confirmatory Test (333)
Linkage Navigation (P28)
Linkage to Care (P25, P26, P27)

B. Social Network Strategy in Non-Clinical Settings [EIN, ESN, SNS]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Coaching	Recruiter Coaching	P54	Individual Event
Rapid HIV Testing	Rapid HIV Testing	218	Individual Event
Confirmatory Test	Confirmatory Test	333	Individual Event
Linkage to Care	Linkage to Care – Within 90 Days	P25	Individual Event
	Linkage Navigation [Not Yet Linked at 90 Days]	P28	Individual Event
	Linkage to Care – >90 through 365 Days	P26	Individual Event
	Linkage to Care – Known Positive	P27	Individual Event

Payability Rules

See Common Rules Section for These Services
Rapid Tests (218)
Confirmatory Test (333)
Linkage Navigation (P28)
Linkage to Care (P25, P26, P27)

Rapid Tests (218)	
Rules Assessed Automatically That May Make Items Recoupable	Within 12 months of the initial test, a recruiter or network associate may be re-tested one time. Otherwise, subsequent testing of the same client is only payable if the client was referred by a different network recruiter.

Recruiter Coaching (P54)	
Rules Assessed Automatically That May Make Items Recoupable	For each recruiter, only seven Recruiter Coaching sessions are payable for the life of the contract.

VI. Ryan White Performance-Based Service Categories

A. Housing Placement Assistance [HPA, HPC]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Housing Placement	Permanent Housing Placement *Placement and maintenance in a permanent type of housing for at least 30 consecutive days.*	047	Individual Event
Non-Reimbursable Housing Placement Services	Short-Term Housing Placement *Placement and maintenance in a transitional or short-term type of housing for at least 30 consecutive days.*	266	Individual Event
	Intake and Assessment	115	Individual Event
	Client Advocacy	281	Individual Event
	Referral to Benefits and Services	470	Individual Event
	Apartment Inspection	P71	Individual Event

Payability Rules

Permanent Housing Placement (047)	
Payment Processing	A placement must have lasted for at least 30 days in order to be processed for payment. A placement record which has an end date in the future will not be processed for payment.
Rules Assessed Automatically That May Make Items Recoupable	Only one placement per client is permitted during a contract year.
Other Rules and/or Data Reporting Required for Compliance with Contract	Programs must follow up on permanent placements on a monthly basis for at least one year post-placement.

B. Care Coordination [MCM, MCC]

General Information

The Care Coordination program provides:

- A holistic and comprehensive approach to meeting the needs of the clients, including medical, supportive, and social needs;
- Client-centered services, culturally and linguistically competent and delivered in a confidential manner;
- A navigation model to advocate for, communicate with, and identify resources for the client, thereby coordinating the complex health care and social service systems necessary to ensure improved client outcomes;
- A chronic care model approach to encourage and support clients to gain and maintain independence in their healthcare as well as to prevent deterioration, reduce the risk of complications, prevent associated illnesses, and enable persons living with chronic conditions to have an improved quality life;
- A provision of formal linkages between HIV primary care providers and the care coordination providers, ensuring that the health information necessary for patient care is available to the Care Coordinator and to all involved providers;
- A uniform Ryan White Program-wide medical practice guideline;
- An integrated medical information system that ensures a relationship between one patient, one primary care provider, and one care coordinator.

Program Goals

- Ensure that PLWHA are promptly linked to medical services at the time of diagnosis and are provided all necessary supports and resources to safeguard lifelong and regular access to effective, quality healthcare.
- Reduce duplication of medical and social support services
- Reduce premature and excess morbidity and mortality by ensuring engagement in primary care and preventive services, reduce excess morbidity

Program Objectives

- Ensure that all enrolled clients are seen by an HIV provider for disease staging and treatment planning within 30 days but no later than 60 days;
- Support the delivery of preventive and primary care to enrolled clients by facilitating adherence to scheduled appointments;
- Ensure that needs for support services (i.e., food, housing, transportation, etc.) are met.
- Support the establishment and availability of a medical home for all enrolled clients;
- Expand on the success of ARV regimens by tailoring adherence support interventions to individual needs and by coordinating the enrolled client's medication management within an interdisciplinary team;
- Promote client autonomy and self-efficacy by means of a comprehensive, interactive, skills building curriculum;
- Help enrolled clients better navigate a complex healthcare system and manage their medical and social needs more autonomously;
- Provide client-centered, culturally and linguistically competent services.

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Per-Member-Per-Day Fee *[Two versions of PHS Service Code represent*	Per Day Enrolled in Intervention A: Non-ARV Health Promotion-Quarterly *See Care Coordination Program Guide for information on levels of service.*	M20 or M34	

Service Family	PHS Service Type	PHS Code	Payment Type
rates for Ryan White Only and COBRA Dually Enrolled Clients]	Per Day Enrolled in Intervention B: ARV Health Promotion – Quarterly *See Care Coordination Program Guide for information on levels of service.*	M21 or M35	
	Per Day Enrolled in Intervention C1: Monthly *See Care Coordination Program Guide for information on levels of service.*	M22 or M36	
	Per Day Enrolled in Intervention C2: Weekly *See Care Coordination Program Guide for information on levels of service.*	M23 or M37	
	Per Day Enrolled in Intervention D: Daily DOT *See Care Coordination Program Guide for information on levels of service.*	M24 or M38	
Directly Observed Therapy	DOT Visit in Clinic *See Care Coordination Program Guide for information.*	M31	Individual Event
	DOT Visit in the Field/Home *See Care Coordination Program Guide for information.*	M32	Individual Event

Payability Rules

Service Threshold Rules for Validating Per-Member-Per-Day Enrollment Fees

Each day of Per-Member-Per-Day enrollment will individually be assessed to determine whether the required threshold of service was reached during the period of time leading up to and including that day. Days which fail to meet the threshold are not payable.

A grace period of 29 days will be paid without being assessed for the required threshold of service. The grace period will begin at enrollment and each time a client is transitioned to a different intervention track. Assessment will begin on the 30th day in the track. Service providers should ensure that they provide sufficient services during the grace period so that enrollment will be payable from the 30th day onward.

The following service types count as "Face-to-Face" services for the purpose of reaching thresholds:

Service Type	RW Only Clients	Dual-Enrolled Clients
Case finding	Yes	No
Intake assessment	Yes	Yes
Medical assessment/reassessment	Yes	Yes
Other assessment/reassessment	Yes	Yes
Care plan/service plan	Yes	Yes
Case conference	Yes	Yes
Accompaniment	Yes	No
Assistance with entitlements & benefits	Yes	No
Assistance with health care	Yes	No
Assistance with housing	Yes	No
Assistance with social services	Yes	No
Health education / promotion	Yes	Yes
Health education - Group	Yes	Yes

Additional requirements in order to count as "Face-to-Face" services:

- The service site must not be "Phone"
- For the "Assistance with…" service types, the service detail must not be "Reminder call/message" or "Court Advocacy"
- For the "Health education / promotion" service type, topics under the rubric of "Non-Care Coordination health education

conversations…" do not count.
- For the "Care plan/service plan" service type, the service detail must not be "Housing services plan" or "Discharge plan".
- For the "Other assessment/reassessment" service type, the service detail must not be "Health assessment", "Client risk assessment", "Mental health", "Harm reduction", "Case management", "Nutritional assessment" or "90-day follow up".

Frequency requirements are as follows:
- For Tracks C2 and D, there must have been at least one Face-to-Face service done in the 15-day period leading up to and including the day being assessed, or at least two Face-to-Face services done in the 30-day period leading up to and including the day being assessed.
- For Track C1, there must have been at least one Face-to-Face service done in the 46-day period leading up to and including the day being assessed, or at least two Face-to-Face services done in the 92-day period leading up to and including the day being assessed.
- For Tracks B and A, there must have been at least one Face-to-Face service done within the 183-day period leading up to and including the day being assessed.

In addition to the ways of meeting thresholds detailed above, Ryan White Only clients in Tracks C1, C2 and D will remain in payable status if there is either:
- An Outreach for Reengagement service within the seven days leading up to and including the day being assessed, which has the service detail "Home Visit" or "Search in Other Locations" and the service site "Client Home" or "Other Field Site". The Outreach service must have occurred no more than 60 days after the most recent Face-to-Face service. OR
- An Outreach for Reengagement service within the three days leading up to and including the day being assessed, which has the service detail "Letter", "Phone Call" or "E-mail or text message". The Outreach service must have occurred no more than 30 days after the most recent Face-to-Face service.

Per-Member-Per-Day	
Payment Processing	Per-Member-Per-Day fees depend on correct entry in eSHARE of the patient's intervention track and the changes from one track to another over time. Intervention tracks are entered through the Intake Assessment and Patient Status Change forms in eSHARE. Only track changes that have been entered into the Patient Status Change form will count toward payment calculations. (Identification of the new track in a Case Conference Form, or in a progress note, is not sufficient to affect payment.) In instances where a client has more than one Intake Assessment and/or Patient Status Change form referring to the same intervention track enrollment date, Public Health Solutions' payment system will use the information (track and reason for change) contained in the last form created; information in forms created earlier on that date will be disregarded. Per-Member-Per-Day fees also depend on correct entry in eSHARE of the overall case opening and closure. In order for the client's last day in the program to be paid, the case closure date entered into eSHARE must be one (1) day after that date.

Directly Observed Therapy (M31, M32)	
Payment Processing	Directly Observed Therapy services provided over the phone will not be processed for payment.
Rules Assessed Automatically That May Make Items Recoupable	Directly Observed Therapy sessions for ART are only payable if the client is currently enrolled in Track D.

C. Transitional Care Coordination [TCC]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Case Finding & Verification	Targeted Case Finding	545	Anon Group - PAID AS EVENT
Care Coordination	Intake and Assessment	115	Individual Event
	Comprehensive Care Plan Development	225	Individual Event
	Reassessment	076	Individual Event
	Comprehensive Care Plan Update	226	Individual Event
	Coordination with Service Providers	P29	Individual Event
	Accompaniment Services	030	Individual Event
Milestone Services	Linkage to Primary Care – Known Positive – Any Timeframe	P27	Individual Event
	Linkage to Housing Services	P23	Individual Event
	Health Promotion	P22	Individual Event
	Transfer to Case Management	P45	Individual Event
	Graduation	P24	Individual Event

Payability Rules

See Common Rules Section for These Services
Targeted Case Finding (545)
Reassessment (076)
Linkage to Primary Care (P27)
Intake & Assessment (115)
Comprehensive Care Plan Development (225)

Reassessment (076)	
Rules Assessed Automatically That May Make Items Recoupable	Only four Reassessment services are payable within a 365-day period.

Comprehensive Care Plan Update (226)	
Rules Assessed Automatically That May Make Items Recoupable	Only four Comprehensive Care Plan Reassessment and Update services are payable within a 365-day period.

Transfer to Case Management (P45)	
Rules Assessed Automatically That May Make Items Recoupable	Only one Transfer to Case Management is payable for each client enrollment period.

Linkage to Primary Care (P27)	
Rules Assessed Automatically That May Make Items Recoupable	Only one Linkage to Primary Care is payable for each client enrollment period.

Linkage to Housing Services (P23)	
Payment Processing	A linkage to housing services will not be processed for payment unless it is indicated in eSHARE that the client attended an appointment on a specific date.
Rules Assessed Automatically That May Make Items Recoupable	Only one Linkage to Housing Services is payable for each client enrollment period.

Graduation (P24)	
Payment Processing	Graduation will be credited when the client has been enrolled continuously (without disenrollment /reenrollment) for at least nine months and has received the following services: • Linkage to Housing Services (P23) • Linkage to Primary Care (P27) OR a linkage via the work of another case management agency. The latter option must be indicated in eSHARE as a Coordination with Service Providers with details specifying Primary Care and Verification. • Transfer to Case Management Program (P45) • Health Promotion (P22) sessions on at least six different topics Only one Graduation is payable for each client enrollment period.

D. Outreach to Homeless Youth [OHY]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Case Finding and Preparation	Targeted Case Finding	545	Anon Group - PAID AS EVENT
	Testing Readiness Counseling	P15	Individual Event
Rapid HIV Testing	Rapid HIV Testing	218	Individual Event
Confirmatory Test	Confirmatory Test	333	Individual Event
Readiness for Primary Care	Readiness for Primary Care Counseling – Individual	P16	Individual Event
	Readiness for Primary Care Counseling – Family	P17	Family/Group - PAID AS EVENT
	Readiness for Primary Care Counseling – Group	P18	Family/Group - PAID AS EVENT
Linkage to Care	Linkage to Care – Within 90 Days [Identified by Testing]	P25	Individual Event
	Linkage Navigation [Not Yet Linked at 90 Days] [Identified by Testing]	P28	Individual Event
	Linkage to Care – >90 through 365 Days [Identified by Testing]	P26	Individual Event
	Linkage to Care [Known Positive]	P27	Individual Event
Referrals for Housing & Supportive Services	Referrals for Housing & Supportive Services – HIV Positive	P19	Individual Event
	Referrals for Housing & Supportive Services – HIV Negative	P20	Individual Event
Other Services	Psychosocial and Client Risk Assessment	P21	Individual Event
	Accompaniment Services	030	Individual Event
	Coordination with Service Providers	P29	Individual Event
	Health Promotion	P22	Individual Event

Payability Rules

General	
Rules Assessed Automatically That May Make Items Recoupable	Duplicates and possible duplicates (same service on same day for same client) may be marked. Possible duplicates that are in fact separate services may require attestation at closeout. Services provided to HIV-negative clients more than twelve months after program enrollment are not payable. Services provided to HIV-positive clients more than eighteen months after program enrollment are usually not payable. However, service providers may request a waiver from Public Health Solutions (subject to DOHMH approval) to provide services in excess of 18 consecutive months for positives not yet linked to care. Waivers will be reviewed on a case by case basis. Services are not payable more than 90 days after the client has had a Linkage to Care (Code P25, P26 or P27) under the OHY program or any other DOHMH-funded program in the same agency.

See Common Rules Section for These Services
Targeted Case Finding (545)
Rapid Tests (218)
Confirmatory Test (333)
Linkage Navigation (P28)
Linkage to Care (P25, P26, P27)

Testing Readiness (P15)	
Rules Assessed Automatically That May Make Items Recoupable	No more than three Testing Readiness sessions per client are payable within each 90-day period. Testing Readiness sessions are not payable for clients having a positive HIV status prior to the date of service.

Rapid Tests (218)	
Rules Assessed Automatically That May Make Items Recoupable	Negative clients must be closed out after the end of a 12 month period. If they continue to be high risk, they may be re-opened for another 12 month period.

Psychosocial and Client Risk Assessment (P21)	
Rules Assessed Automatically That May Make Items Recoupable	No more than two Psychosocial and Client Risk Assessments per client are payable within each 12-month period.
Payment Processing	Payment for Psychosocial and Client Risk Assessment will only be processed for clients who are HIV+.

Readiness for Primary Care Individual and Family Counseling (P16, P17)	
Payment Processing	Sessions are not payable if the client does not have a positive HIV status on the date of service.
Rules Assessed Automatically That May Make Items Recoupable	A maximum of four individual and family sessions are payable in any given month, with a limit of twelve services payable during an enrollment.

Referrals for Housing and Supportive Services – HIV+ (P19)	
Payment Processing	Sessions are not payable if the client does not have a positive HIV status on the date of service.

Referrals for Housing and Supportive Services – HIV- (P20)	
Rules Assessed Automatically That May Make Items Recoupable	Referrals are only payable for clients having a negative HIV status, not for clients whose status is still unknown. A maximum of three referrals are payable following each HIV test.

Accompaniment Services (030)	
Payment Processing	Accompaniment is only payable for clients who are HIV+.

Coordination with Service Providers (P29)	
Payment Processing	Coordination with service providers is only payable for clients who are HIV+.

Readiness for Primary Care Counseling – Groups (P18)	
Rules Assessed Automatically That May Make Items Recoupable	Services are only payable if they have at least three Ryan White participants. In the situation of only one or two participants arriving for a scheduled group service, a service provider may provide each client with a separate individual counseling session. Providing a joint service to two participants and reporting it as two individual services is not permitted.

Readiness for Primary Care Counseling – Family (P17)	
Rules Assessed During Site Visits That May Make Items Recoupable	Family services (P17) are only payable if they have at least two participants.

Health Promotion (P22)	
Rules Assessed Automatically That May Make Items Recoupable	A maximum of four Health Promotion services are payable in a given month. A maximum of twelve Health Promotion services are payable over the course of a client's enrollment.
Payment Processing	Payment for Health Promotion will only be processed for clients who are HIV+.

E. Food and Nutrition Services [FNS]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Assessment & Treatment Planning	Intake and Assessment	115	Individual Event
	Comprehensive Treatment Plan Development	225	Individual Event
	Reassessment	076	Individual Event
	Comprehensive Care Plan Update	226	Individual Event
Linkage to Care	Verification of Connection to HIV Primary Care	247	Individual Event
	Linkage to Care	P27	Individual Event
Nutritional Services	Comprehensive Nutritional Assessment	035	Individual Event
	Nutritional Counseling w/o Supplements	P10	Individual Event
	Nutritional Counseling w/Supplements	P09	Individual Event
	Nutritional Education Group	061	Family/Group - PAID AS EVENT
Food Services	Congregate Meals	P46	Group - PAID PER ATTENDEE - NO CAP
	Home-Delivered Meals	046	Individual Event
	Pantry Bags Distribution	066	Individual Event
	Supplemental Food Voucher - $20	P13	Individual Event
	Emergency Food Voucher - $40	P14	Individual Event

Payability Rules

See Common Rules Section for These Services
Reassessment (076)
Intake & Assessment (115)
Comprehensive Care Plan Development (225)

Comprehensive Care Plan Update (226)	
Rules Assessed Automatically That May Make Items Recoupable	Only three services of each of these types is payable per client within a twelve-month period.

Verification of Connection to HIV Primary Care (247)	
Payment Processing	The payment system will only recognize this service if the sub-detail “Verification” has been entered.

Comprehensive Nutritional Assessment (035)	
Rules Assessed Automatically That May Make Items Recoupable	Only one comprehensive nutritional assessment per client is payable within an enrollment period.

Individual Nutritional Counseling (P09 and P10)	
Rules Assessed Automatically That May Make Items Recoupable	Only one nutritional counseling session per client within a seven-day period is payable.

Nutritional Education Group (061)	
Rules Assessed Automatically That May Make Items Recoupable	A nutritional education group is only payable if at least three participants attend.
Rules Assessed During Site Visits That May Make Items Recoupable	Only one nutritional education group per client within a seven-day period is payable.

Congregate Meals, Home-Delivered Meals and Pantry Bag Distribution (P46, 046, 066)	
Rules Assessed During Site Visits That May Make Items Recoupable	No more than fourteen meals of all three types together (congregate meals, home-delivered meals, pantry bag distribution) per index client are payable per week. An index client's dependent children are the only collaterals who are eligible to receive meals.

F. Supportive Counseling and Family Stabilization [SCG, SCI, SCP]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Assessment & Planning	Intake Assessment	115	Individual Event
	Reassessment	076	Individual Event
	Service Plan Development	225	Individual Event
	Service Plan Update	226	Individual Event
Staff Travel	Travel – Higher Rate	P81	Individual Event
	Travel – Lower Rate	P83	Individual Event
Service Coordination	Accompaniment	030	Individual Event
	Accompaniment – With Translation	P82	Individual Event
	Client Assistance	P85	Individual Event
	Coordination with Service Providers	P29	Individual Event
	Coordination with Service Providers – With Translation	P84	Individual Event
	Outreach for Client Re-engagement	P56	Individual Event
Supportive Counseling	Biomedical Counseling – Partners	P86	Individual Event
	Family Counseling	329	Family/Group - PAID AS EVENT
	Group Counseling – Supportive	P91	Group - PAID PER ATTENDEE - CAP
	Individual Counseling	319	Individual Event
	Pastoral Counseling	P80	Individual Event
Evidence – Based Interventions	Seeking Safety – Individual	P61	Individual Event
	Seeking Safety – Group	Q14	Group - PAID PER ATTENDEE - CAP

Payability Rules

See Common Rules Section for These Services
Reassessment (076)
Outreach for Client Reengagement (P56)
Intake & Assessment (115)
Service Plan Development (225)
Service Plan Update (226)
Group Counseling – Supportive (P91)
Seeking Safety – Individual (P61)
Seeking Safety – Group (Q14)

Group Counseling – Supportive (P91)	
Payment Processing	The payment unit is the attendee. A maximum of six attendees are payable per session.

G. General Non-Medical Case Management [NMG]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Assessment & Planning	Intake Assessment	115	Individual Event
	Reassessment	076	Individual Event
	Service Plan Development	225	Individual Event
	Service Plan Update	226	Individual Event
Service Coordination	Accompaniment	030	Individual Event
	Accompaniment – With Translation	P82	Individual Event
	Client Assistance	P85	Individual Event
	Coordination with Service Providers	P29	Individual Event
	Coordination with Service Providers – With Translation	P84	Individual Event
	Outreach for Client Re-engagement – Home	H01	Individual Event
	Outreach for Client Re-engagement – Office	H02	Individual Event

Payability Rules

See Common Rules Section for These Services
Reassessment (076)
Intake & Assessment (115)
Service Plan Development (225)
Service Plan Update (226)

Outreach for Client Reengagement (H01 & H02)	
Payment Processing	An outreach for client reengagement is payable only within the 90 days following the most recent face-to-face service with the client.

H. Health Education and Risk Reduction [HER]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Case Finding	Targeted Case Finding	545	Anonymous Group - PAID AS EVENT
Assessment and Planning	Intake Assessment	115	Individual Event
	Outcome Evaluation - PreTest	Q03	Individual Event
	Outcome Evaluation - PostTest	Q04	Individual Event
	Outcome Evaluation - 90 Day	Q05	Individual Event
Service Coordination	Referral and Assistance	P93	Individual Event
Health Education	Alumni Series	Q06	Group - PAID PER ATTENDEE - NO CAP
	Health Workshop	Q07	Group - PAID PER ATTENDEE - NO CAP

Payability Rules

Alumni Series (Q06)	
Payment Processing	Only payable if it occurs on the same day or after an Outcome Evaluation – Post Test (Q04) for the same client.

Health Workshop (Q07)	
Rules Assessed Automatically That May Make Items Recoupable	The Health Workshop is recoupable if it occurs after an Outcome Evaluation – Post Test (Q04) for the same client.

I. Harm Reduction Services [HRM]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Case Finding	Targeted Case Finding	545	Anonymous Group - PAID AS EVENT
Assessment and Planning	Intake Assessment	115	Individual Event
	Service Plan Development	225	Individual Event
	Reassessment	076	Individual Event
	Service Plan Update	226	Individual Event
AOD Services	Individual Counseling - AOD	049	Individual Event
	Group Counseling - AOD	P87	Group - PAID PER ATTENDEE - CAP
	Family Counseling - AOD	031	Family/Group - PAID AS EVENT
	Auricular Acupuncture	286	Individual Event
	Overdose Prevention Training - Individual	262	Individual Event
	Overdose Prevention Training - Group	Q12	Group - PAID PER ATTENDEE - CAP
	Overdose Prevention Training - Family	Q11	Family/Group - PAID AS EVENT
Health Education	Biomedical Counseling - Partners	P86	Individual Event
	One-on-One Health Promotion	P22	Individual Event
Service Coordination	Accompaniment	030	Individual Event
	Care Coordination - Primary Care Provider	247	Individual Event
	Client Engagement Activities	P55	Individual Event
	Outreach for Client Reengagement	P56	Individual Event
	Travel - Higher Rate	P81	Individual Event
	Travel - Lower Rate	P83	Individual Event
	Client Assistance	P85	Individual Event
Medical Services	Buprenorphine Initial Visit	276	Individual Event
	Buprenorphine Routine Visit	277	Individual Event
Evidence-Based Interventions	Therapeutic Education System	Q16	Individual Event
	Seeking Safety - Individual	P61	Individual Event
	Seeking Safety - Group	Q14	Group - PAID PER ATTENDEE - CAP
	Healthy Living Project	P62	Individual Event

Payability Rules

See Common Rules Section for These Services
Targeted Case Finding (545)
Outreach for Client Reengagement (P56)
Service Plan Update (226)
Family Counseling - AOD (031)
Care Coordination - Primary Care Provider (247)
Overdose Prevention Training - Family (Q11)
Overdose Prevention Training - Group (Q12)
Group Counseling - AOD (P87)
Reassessment (076)
Seeking Safety - Individual (P61)
Seeking Safety - Group (Q14)

Targeted Case Finding (545)	
Payment Processing	The event must last at least two hours.

Group Counseling - AOD (P87)	
Payment Processing	The payment unit is the attendee. A maximum of six attendees are payable per session.

Auricular Acupuncture (286)	
Rules Assessed Automatically That May Make Items Recoupable	Only 12 Acupuncture services authorized per month per client.

Healthy Living Project (P62)	
Payment Processing	The payment unit is the attendee. A maximum of six attendees are payable per session.

Overdose Prevention Training - Group (Q12)	
Payment Processing	The payment unit is the attendee. A maximum of six attendees are payable per session.

Therapeutic Education System (Q16)	
Rules Assessed Automatically That May Make Items Recoupable	Only one Therapeutic Education per day per client.

J. Mental Health Services [MHV]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Assessment & Planning	Mental Health Intake and Assessment	058	Anonymous Group - PAID AS EVENT
	Service Plan Development	225	Individual Event
	Reassessment	076	Individual Event
	Service Plan Update	226	Individual Event
Mental Health Services	Individual Counseling - MH	050	Individual Event
	Group Counseling - MH	P88	Group - PAID PER ATTENDEE - CAP
	Family Counseling - MH	032	Family/Group - PAID AS EVENT
	Psychiatric Evaluation	073	Individual Event
	Psychiatric Visits	074	Individual Event
	Travel - Higher Rate	P81	Individual Event
	Travel - Lower Rate	P83	Individual Event
Other Counseling Services	Individual Counseling - AOD	049	Individual Event
	Group Counseling - AOD	P87	Group - PAID PER ATTENDEE - CAP
	Family Counseling - AOD	031	Family/Group - PAID AS EVENT
	Individual Counseling - Treatment Adherence	239	Individual Event
	Group Counseling - Treatment Adherence	P89	Group - PAID PER ATTENDEE - CAP
	Family Counseling - Treatment Adherence	237	Family/Group - PAID AS EVENT
	Biomedical Counseling - Partners	P86	Individual Event
	Wellness Individual	P57	Individual Event
	Wellness Group	Q15	Group - PAID PER ATTENDEE - CAP
Service Coordination	Care Coordination - Primary Care Provider	247	Individual Event
	Client Assistance	P85	Individual Event
	Accompaniment	030	Individual Event
	Outreach for Client Reengagement	P56	Individual Event
	Client Engagement Activities	P55	Individual Event
Evidence-Based Interventions	Seeking Safety - Individual	P61	Individual Event
	Seeking Safety - Group	Q14	Group - PAID PER ATTENDEE - CAP

Payability Rules

See Common Rules Section for These Services
Outreach for Client Reengagement (P56)
Service Plan Update (226)
Care Coordination - Primary Care Provider (247)
Mental Health Counseling - Group (P88)
Treatment Adherence Counseling - Group (P89)
Seeking Safety - Group (Q14)
AOD Counseling - Group (P87)
Reassessment (076)
Seeking Safety - Individual (P61)

AOD Counseling Services - Family (031), Individual (049), and Group (P87)	
Rules Assessed Automatically That May Make Items Recoupable	Only ten services are payable per month.

Mental Health Counseling Services - Family (032), Individual (050), and Group (P88)	
Rules Assessed Automatically That May Make Items Recoupable	Only ten services are payable per month.

Treatment Adherence Counseling Services - Family (237), Individual (239), Group (P89)	
Rules Assessed Automatically That May Make Items Recoupable	Only two services are payable per month.

Group Services - Treatment Adherence Counseling (P89), Mental Health Counseling (P88), and AOD Counseling (P87)	
Payment Processing	The payment unit is the attendee. A maximum of six attendees are payable per session.

VII. Prevention Performance-Based Service Categories

A. Enhanced Condom Distribution Services [CON]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Condoms	Recruitment	C18	Anon Group - PAID AS EVENT
	Non-Traditional Distribution Sites: Monthly Maintenance of Network	C04	Anon Group - PAID AS EVENT
	Distribution at Health Fairs / Neighborhood Events	C05	Anon Group - PAID AS EVENT
	Distribution at High-Risk Venues	C06	Anon Group - PAID AS EVENT
	Distribution – Street Outreach	C07	Anon Group - PAID AS EVENT

Payability Rules

All Service Types	
Rules Assessed Automatically That May Make Items Recoupable	Services are only payable if they occur at venues within zip codes specified in their contract scope documents.

Recruitment (C18)	
Payment Processing	A recruitment payment will be processed for the first time a new venue receives a distribution of at least 250 male condoms.

Non-Traditional Distribution Sites – Monthly Maintenance of Network (C04)	
Payment Processing	A monthly payment will be processed for each month during which at least 250 male condoms have been distributed, provided that 250 male condoms were also distributed during at least one of the previous two months.

Distribution at Health Fairs / Neighborhood Events (C05)	
Payment Processing	In order to be paid, a health fair or neighborhood event must last for at least four hours and must distribute at least 600 male condoms. For each venue, only two health fair or neighborhood events are payable each year. Records that do not specify a venue will not be processed for payment.

Distribution at High-Risk Venues and Street Outreach (C06 & C07)	
Payment Processing	In order to be paid, a distribution at a high-risk venue or via street outreach must last for at least two hours. Records that do not specify a venue will not be processed for payment.

B. Sexual and Behavioral Health for Priority Populations [SBH]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Assessments	Intake and Assessment	115	Individual Event
	Reassessment	076	Individual Event
PrEP (Pre-Exposure Prophylaxis)	PrEP Initial Medical Visit	N09	Individual Event
	PrEP Prescription – Medical	N10	Individual Event
	PrEP Prescription – Non-Medical	N11	Individual Event
	PrEP Follow-up – Medical	N12	Individual Event
	PrEP Follow-up – Non-Medical	N13	Individual Event
	PrEP MAP Follow-up	N14	Individual Event
PEP (Post-Exposure Prophylaxis)	PEP Eligibility Assessment	N01	Individual Event
	PEP Initial Medical Visit	N05	Individual Event
	PEP Initial Medical Visit and PAP Visit	N06	Individual Event
	PEP Follow Up – 30 Days	N07	Individual Event
	PEP Follow Up – 90 Days	N08	Individual Event
	PEP Prescription - Medical	N16	Individual Event
	PEP Prescription - Non-Medical	N17	Individual Event
	PEP Follow-up - Weekly	N18	Individual Event
	PEP Starter Packs	N20	Individual Event
HIV Testing Services	Rapid HIV Testing	218	Individual Event
	Confirmatory Test	333	Individual Event
	Linkage to Care – Within 90 Days	P25	Individual Event
	Linkage Navigation [Not Yet Linked at 90 Days]	P28	Individual Event
	Linkage to Care – >90 through 365 Days	P26	Individual Event
Health Education & Mental Health /Substance Use Social Service Counseling/Referral	Counseling - Substance Use Individual	049	Individual Event
	Counseling - Mental Health Individual	050	Individual Event
	Counseling - Substance Use Group	038	Family/Group - PAID AS EVENT
	Health Education-Risk Reduction-Group	220	Family/Group - PAID AS EVENT

Service Family	PHS Service Type	PHS Code	Payment Type
	Health Education-Risk Reduction-Individual	221	Individual Event
	PrEP/PEP/Combination Prevention Education	N19	Individual Event
	Mental Health/Substance Use Screening, Brief Intervention & Referral to Treatment	P96	Individual Event
Linkages	Linkage to Social Services	P69	Individual Event
	Mental Health / Substance Use Referral	P70	Individual Event
[Types Treated as Separate Service Families]	Benefit Navigation	470	Individual Event
	Vaccination	N15	Individual Event
	STI Gonorrhea/Chlamydia Treatment	P97	Individual Event
	STI Syphilis/Gonorrhea/Chlamydia Screening	P65	Individual Event
	STI Syphilis Treatment	P98	Individual Event
	Hepatitis B and C Screenings	P67	Individual Event
	Hepatitis C RNA Testing	P99	Individual Event

Payability Rules

See Common Rules Section for These Services
Rapid Tests (218)
Confirmatory Test (333)
Linkage Navigation (P28)
Linkage to Care (P25, P26)

Mental Health/Substance Use Screening, Brief Intervention & Referral to Treatment (P96)	
Payment Processing	In order to be processed for payment, the record must show that all four screenings (PHQ9, GAD, DAST and AUDIT) have been completed. The record must also show that the client either received or refused the brief intervention for mental health or substance use.

STI Syphilis/Gonorrhea/Chlamydia Screening (P65)	
Payment Processing	An STI screening will not be processed for payment if it occurs during the period between four days before and fourteen days after the client had a PEP Initial Medical Visit (Code N05 or N06), or if it occurs during the period between twenty-eight days before and fourteen days after the client had a PrEP initial medical visit (Code N09). An STI screening will not be processed for payment unless it indicates that at least one test (syphilis, chlamydia or gonorrhea) was carried out.
Rules Assessed Automatically That May Make Items Recoupable	Only two STI screenings are payable per client per contract year.

STI Gonorrhea/Chlamydia Treatment (P97) and STI Syphilis Treatment (P98)	
Payment Processing	An STI treatment record will not be processed for payment unless it indicates that treatment was initiated for the appropriate STD.
Rules Assessed Automatically That May Make Items Recoupable	Only two STI treatment services of each type are payable per client per contract year. Service providers may, on a case-by-case basis, submit requests to DOHMH to make an exception beyond that frequency limit.

Hepatitis B and C Screenings (P67)	
Rules Assessed Automatically That May Make Items Recoupable	Only one hepatitis screening is payable per client per contract year.

Hepatitis C RNA Testing (P99)	
Rules Assessed Automatically That May Make Items Recoupable	Only one Hepatitis C RNA Testing is payable per client per contract year.

PrEP Initial Medical Visit (N09)	
Payment Processing	The following rules apply to the PrEP initial medical visit: Payment will not be processed unless there is an STI screening service within the period between twenty-eight days before and fourteen days after the date of the initial medical visit.
Rules Assessed Automatically That May Make Items Recoupable	Medical visits are not payable unless there is an HIV test on the same day as the medical visit.

Vaccination (N15)	
Rules Assessed Automatically That May Make Items Recoupable	A vaccination service for Hepatitis A (Alone), or for Hepatitis B (Alone), is not payable if the client also has a TwinRex vaccination on the same date.

PEP Initial Medical Visit (N05) *&* PEP Initial Medical Visit and PAP Visit (N06)	
Payment Processing	The following rules apply to the PEP initial medical visit, with or without the Patient Assistance Program (N05 or N06): The medical visit must be performed on site. Payment will not be processed unless: • The medical visit is preceded by a PEP eligibility assessment within the seven days leading up to and including the date of the initial medical visit, with no other initial PEP medical visit (N05 or N06) between the two. • There is an STI screening service within the period between four days before and fourteen days after the date of the initial medical visit.
Rules Assessed Automatically That May Make Items Recoupable	Medical visits are not payable unless there is an HIV test on the same day as the medical visit.

PEP Follow Up – 30 Days (N07) *&* PEP Follow Up – 90 Days (N08)	
Payment Processing	A PEP follow up medical visit will not be processed for payment unless it is preceded by a PEP initial medical visit (N05 or N06), with no other PEP follow up visit of the same type between the two.
Rules Assessed Automatically That May Make Items Recoupable	PEP Follow Up – 30 Day and 90 Day visits are not payable unless there is an HIV test on the same day as the medical visit.

PEP Follow Up – Weekly (N18)	
Payment Processing	A PEP Follow-up – Weekly (Code N18) must occur no more than 28 days after an initial medical visit (Code N05 or N06) in order to be processed for payment.
Rules Assessed Automatically That May Make Items Recoupable	No more than three PEP Follow Up – Weekly visits are payable after each PEP initial medical visit (N05 or N06).

Health Education-Risk Reduction-Group (220) *&* Counseling - Substance Use Group (038)	
Rules Assessed Automatically That May Make Items Recoupable	Groups are not payable if they do not have at least three participants.

Linkage to Social Services (P69) *&* Mental Health/Substance Use Referral (P70)	
Rules Assessed Automatically That May Make Items Recoupable	Each referral type (e.g. to Legal Services, to Health Insurance, to Mental Health Services) is only payable once per client. The Linkage to Social Services (P69) is only payable if its disposition is one of the following three: Completed, Refused or cancelled by agency staff, Client showed but appointment not completed, not rescheduled.

Counseling - Substance Use Group (049) & Counseling - Mental Health Individual (050)	
Rules Assessed Automatically That May Make Items Recoupable	Only ten individual counseling – AOD services per contract year per client are payable. Only ten individual counseling – MH services per contract year per client are payable.

Rapid Tests (218)	
Payment Processing	A test will not be processed for payment if there is a PEP initial medical visit (N05 or N06) or a PrEP initial medical visit (N09) on the same date.

C. Community-Level Interventions [CLI]

Service Families and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Community Promise	Community PROMISE Role Model Story Distributions	EYM	Anon Group - PAID PER ATTENDEE
	Community PROMISE Focus Groups	EYI	Anon Group - PAID AS EVENT
	Community PROMISE Anonymous Events	EYL	Anon Group - PAID AS EVENT
	Community PROMISE Conversations in the Community	EYN	Anon Group - PAID PER ATTENDEE
	Community PROMISE Venue-Based Material Distribution	EYK	Anon Group - PAID AS EVENT
D-Up	D-Up Training Session 01	EYA	Family/Group - PAID AS EVENT
	D-Up Training Session 01-B	EYO	Family/Group - PAID AS EVENT
	D-Up Training Session 02	EYB	Family/Group - PAID AS EVENT
	D-Up Training Session 03	EYC	Family/Group - PAID AS EVENT
	D-Up Training Session 04	EYD	Family/Group - PAID AS EVENT
	D-Up Meetings	EYE	Family/Group - PAID AS EVENT
	D-Up Individual Coaching	EYF	Individual Event
	D-Up Conversations in the Community	EYG	Anon Group - PAID PER ATTENDEE
	D-Up Peer Training Completion	0EY	Individual Event
Popular Opinion Leaders (POL)	POL Conversations in the Community	ENA	Anon Group - PAID PER ATTENDEE
	POL Meetings	ENG	Family/Group - PAID AS EVENT
	POL Training Session 01	ENC	Family/Group - PAID AS EVENT
	POL Training Session 02	END	Family/Group - PAID AS EVENT
	POL Training Session 03	ENE	Family/Group - PAID AS EVENT
	POL Training Session 04	ENF	Family/Group - PAID AS EVENT
	POL Individual Coaching	ENB	Individual Event
	POL Client Completion	0EN	Individual Event
MPowerment	MPowerment Informal Outreach Contacts	ELA	Anon Group - PAID PER ATTENDEE
	MPowerment Formal Outreach Events	ELB	Anon Group - PAID AS EVENT
	MPowerment M Groups	ELG	Anon Group - PAID AS EVENT
	MPowerment Social Events	ELC	Anon Group - PAID AS EVENT

Service Family	PHS Service Type	PHS Code	Payment Type
	MPowerment Core Groups	ELD	Family/Group - PAID AS EVENT

Payability Rules

D-Up Conversations in the Community (EYG)	
Payment Processing	Payment will not be processed unless the event occurred at one of the venue types listed in the instructions that have been distributed by DOHMH.

D-Up Group Sessions (EYA, EYB, EYC, EYD, EYE, EYO)	
Rules Assessed Automatically That May Make Items Recoupable	A group session must have at least 3 participants and no more than 15 participants. A group session must last a minimum of 90 minutes.

D-Up Individual Coaching (EYF)	
Rules Assessed Automatically That May Make Items Recoupable	An individual coaching session must last a minimum of 30 minutes.

D-Up Peer Training Completion (0EY)	
Payment Processing	A client's completion of the training is payable based on the client's attendance at all of the following: (1) All five of the training sessions numbered 1 through 4 (EYA, EYO, EYB, EYC, EYD) (2) One booster training, group coaching or reunion meeting (EYE) (3) One individual coaching (peer supervision) session (EYF) All requirements must be completed within 90 days.
Rules Assessed That May Make Items Recoupable	Contractors must complete and submit an attribution form (through SurveyMonkey) prior to the completion of training.

POL Conversations in the Community (ENA)	
Payment Processing	Payment will not be processed unless the event occurred at one of the venue types listed in the instructions that have been distributed by DOHMH.

POL Group Sessions (ENC, END, ENE, ENF, ENG)	
Rules Assessed Automatically That May Make Items Recoupable	A group session must have at least 3 participants and no more than 15 participants. A group session must last a minimum of 90 minutes.

POL Individual Coaching (ENB)	
Rules Assessed Automatically That May Make Items Recoupable	An individual coaching session must last a minimum of 30 minutes.

POL Peer Training Completion (0EN)	
Payment Processing	A client's completion of the training is payable based on the client's attendance at all of the following: (1) All four of the training sessions numbered 1 through 4 (ENC, END, ENE, ENF) (2) One booster training, group coaching or reunion meeting (ENG) (3) One individual coaching (peer supervision) session (ENB) All requirements must be completed within 90 days.
Rules Assessed That May Make Items Recoupable	Contractors must complete and submit an attribution form (through SurveyMonkey) prior to the completion of training.

MPowerment Core Groups (ELD)	
Rules Assessed Automatically That May Make Items Recoupable	A core group session must have at least 3 participants and no more than 15 participants. A core group session must last a minimum of 60 minutes.

MPowerment Anonymous Events (ELB, ELC, ELG)	
Rules Assessed Automatically That May Make Items Recoupable	MPowerment anonymous events must last a minimum of 90 minutes. MPowerment Formal Outreach Events (ELB) must have at least 20 participants. MPowerment Social Events (ELC) must have a minimum of 5 participants. MPowerment M Groups (ELG) must have a minimum of 12 participants and no more than 20 participants.

D. Demonstration Projects [DEM]

Interventions and Service Types

Service Family	PHS Service Type	PHS Code	Payment Type
Targeted Case Finding	Targeted Outreach	P79	Anon Group - PAID PER ATTENDEE
Intake & Screening Services	Assessment or Reassessment	115	Individual Event
HIV Testing	Rapid HIV Testing	218	Individual Event
	Confirmatory Test	333	Individual Event
	Linkage to Care – Within 90 Days [Identified by Testing]	P25	Individual Event
	Linkage Navigation [Not Yet Linked at 90 Days] [Identified by Testing]	P28	Individual Event
	Linkage to Care – >90 through 365 Days [Identified by Testing]	P26	Individual Event
Care Coordination Services	Care Coordination – Case Conferencing	P77	Individual Event
	Drug Treatment Placement	P76	Individual Event
	Linkage to Social Services	470	Individual Event
Primary Sexual & Behavioral Services	Counseling - Substance Use Group	038	Family/Group - PAID AS EVENT
	Counseling - Substance Use Individual	049	Individual Event

Payability Rules

See Common Rules Section for These Services
Rapid Tests (218)
Confirmatory Test (333)
Linkage Navigation (P28)
Linkage to Care (P25, P26)

All Services	
Rules Assessed Automatically That May Make Items Recoupable	In order for a service to be payable, the client must have had an Assessment or Reassessment (115) on or before the date of the service.

Intake Assessment (115)	
Rules Assessed Automatically That May Make Items Recoupable	Only one initial Intake and Assessment (Initial Assessment) is payable per client.

Counseling - Substance Use Group (038)	
Rules Assessed Automatically That May Make Items Recoupable	Substance use counseling groups (038) are only payable if they have at least three participants.

Drug Treatment Placement (P76)	
Payment Processing	A drug treatment placement (P76) will be processed for payment only if a referral for AOD-Substance Abuse Treatment has been entered for that client.

VIII. Common Rules

A. Outreach, Intake, and Service Planning

Case Finding (545)		
OHY TCC HRM	Payment Processing	Only case findings which made at least ten contacts or at least three engagements will be processed for payment.

Intake and Assessment (115)		
FNS TCC	Rules Assessed Automatically That May Make Items Recoupable	Only one Intake & Assessment service is payable for each client enrollment period.
NMG SCG, SCI, SCP	Rules Assessed Automatically That May Make Items Recoupable	Assessment-related services (the original Intake Assessment and subsequent Reassessments) are payable only four times within a 365-day period.

Service Plan Development (225)		
FNS TCC	Rules Assessed Automatically That May Make Items Recoupable	Only one Assessment and Comprehensive Care Plan Development is payable for each client enrollment period.
NMG SCG, SCI, SCP	Rules Assessed Automatically That May Make Items Recoupable	Service Plan-related services (the original Service Plan Development and subsequent Service Plan Updates) are payable only four times within a 365-day period.

Reassessment (076)		
FNS HRM MHV NMG SCG, SCI, SCP TCC	Payment Processing	A reassessment service (Code 076), which is based on the eSHARE service type detail 'Reassessment (clinical, psychosocial, general health/well-being, housing, enrollments, etc.)', will not be recognized unless both an Individual Services Delivered form and a Reassessment form have been entered in eSHARE, with the service date on the former having the same date as the Date of Reassessment on the latter.
HRM MHV	Rules Assessed Automatically That May Make Items Recoupable	Only one reassessment per six months.

Service Plan Update (226)		
HRM MHV	Rules Assessed Automatically That May Make Items Recoupable	Only one Service Plan Update per six months.
NMG SCG, SCI, SCP	Rules Assessed Automatically That May Make Items Recoupable	Service Plan Updates are payable only four times within a 365-day period.

B. HIV Testing and Linkage to Care

HIV Pre-test Counseling and Rapid Testing (218)		
EIR, ESR, HTR, HRX EIP, ESP, HPT, PPT EIN, ESN, SNS OHY SBH DEM	Payment Processing	A test record that has no test result will not be processed for payment.
	Rules Assessed Automatically That May Make Items Recoupable	(1) A second rapid test on the same day is assumed to be a data entry mistake unless the first one is via oral/mucosal specimen with a reactive result and the second one is via fingerstick/venipuncture specimen. (Agencies may supplement the initial reactive result prior to delivering the results and ordering a confirmatory test.) To be payable, both rapid tests must be entered under the same eSHARE Form ID. Except in that circumstance, a second rapid test after a reactive one is not payable.
EIR, ESR, HTR, HRX EIP, ESP, HPT, PPT EIN, ESN, SNS OHY SBH DEM	Rules Assessed Automatically That May Make Items Recoupable	(2) Any test that is reported for the same client on the same day in more than one of an agency's contracts will have both records (under both contracts) marked for recoupment. It is the responsibility of the agency to review marked records, determine which contract actually provided the test, and correct the reporting.
EIR, ESR, HTR, HRX EIP, ESP, HPT, PPT OHY DEM	Rules Assessed Automatically That May Make Items Recoupable	An HIV test is not payable if the client also has, on the same day, a PEP or PrEP initial medical visit, or a PEP follow up visit (Code N05, N06, N07, N08, N09), under a Sexual and Behavioral Health (SBH) contract.
EIR, ESR, HTR, HRX EIP, ESP, HPT, PPT OHY SBH DEM	Rules Assessed Automatically That May Make Items Recoupable	Each client may be tested up to four times per contract year.

HIV Positive Confirmatory Test, Results Provided (333)		
EIR, ESR, HTR, HRX EIP, ESP, HPT, PPT EIN, ESN, SNS OHY SBH DEM	Payment Processing	A confirmatory test that does not have an earlier HIV antibody test entered in eSHARE under the same Form ID will not be processed for payment.
	Rules Assessed Automatically That May Make Items Recoupable	A confirmatory test is only payable if an earlier HIV antibody test was reactive OR if the confirmatory test uses NAAT/RNA technology. Only one confirmatory test per client is payable, with the exception of situations where a second test is necessary because the first test was (a) indeterminate; (b) negative and an OraSure HIV-1 western blot; or (c) invalid. A confirmatory test is not payable if it is performed using rapid test technology.

Payment Processing: A linkage to care will not be processed for payment unless it is indicated in eSHARE that the client attended an appointment on a specific date.							
	EIR, ESR, HTR, HRX	**EIP, ESP, HPT, PPT**	**EIN, ESN, SNS**	**OHY**	**SBH**	**DEM**	**TCC**
Linkage to Care within 90 days (P25)	✓	✓	✓	✓	✓	✓	
Linkage to Care between 91 and 365 days [Identified by Testing] (P26)	✓	✓	✓	✓	✓	✓	
Linkage to Care for Known Positive - Any Timeframe (P27)	✓	✓	✓	✓			✓

Payment Processing: A linkage to care will not be processed for payment unless there is an earlier confirmatory test with a positive/reactive result entered in eSHARE under the same Form ID.						
	EIR, ESR, HTR, HRX	**EIP, ESP, HPT, PPT**	**EIN, ESN, SNS**	**OHY**	**SBH**	**DEM**
Linkage to Care within 90 days (P25)	✓	✓	✓	✓	✓	✓
Linkage to Care between 91 and 365 days [Identified by Testing] (P26)	✓	✓	✓	✓	✓	✓

Recoupment Rules: A second linkage to care for the same client is not payable.						
	EIR, ESR, HTR, HRX	**EIP, ESP, HPT, PPT**	**EIN, ESN, SNS**	**OHY**	**SBH**	**DEM**
Linkage to Care within 90 days (P25)	✓	✓	✓	✓	✓	✓
Linkage to Care between 91 and 365 days [Identified by Testing] (P26)	✓	✓	✓	✓	✓	✓
Linkage to Care for Known Positive - Any Timeframe (P27)	✓	✓	✓	✓		

Linkage to Care for Known Positive - Any Timeframe (P27)		
EIR, ESR, HTR, HRX EIP, ESP, HPT, PPT EIN, ESN, SNS OHY TCC	Payment Processing	A linkage to care will not be processed for payment unless it is indicated in eSHARE that the client attended an appointment on a specific date.

Linkage Navigation [Not Yet Linked at 90 Days] [Identified by Testing] (P28)		
EIR, ESR, HTR, HRX EIP, ESP, HPT, PPT EIN, ESN, SNS OHY SBH DEM	Payment Processing	A Linkage Navigation will not be processed for payment unless the client has an earlier confirmatory test under the same Form ID.
	Rules Assessed Automatically That May Make Items Recoupable	A Linkage Navigation is not payable if its date is more than 365 days after the original Rapid Test. A Linkage Navigation is not payable if the same client has a Linkage to Care – Known Positive (Code P27) within 365 days after the original Rapid Test.

C. Other Individual Services

Care Coordination - Primary Care Provider (247)		
HRM MHV	Rules Assessed Automatically That May Make Items Recoupable	Only one Care Coordination - Primary Care Provider per 90 days.

Outreach for Client Reengagement (P56)		
HRM MHV SCG, SCI, SCP	Payment Processing	An outreach for client reengagement is payable only within the 90 days following the most recent face-to-face service with the client.

Seeking Safety - Individual (P61)		
HRM MHV SCG, SCI, SCP	Rules Assessed Automatically That May Make Items Recoupable	Only one Seeking Safety - Individual is payable per day per client.

D. Family and Group Services

Recoupment Rules: Family Services that are only payable if they have at least two participants.		
	HRM	**MHV**
AOD Counseling - Family (031)	✓	✓
Mental Health Counseling - Family (032)		✓
Treatment Adherence Counseling - Family (237)		✓
Overdose Prevention Training - Family (Q11)	✓	

Recoupment Rules: Group Services that are only payable if they have at least three participants. Services are not payable if they do not have at least three participants, including both those paid by Ryan White and those paid by other funding sources. In the situation of only one or two participants arriving for a scheduled group service, a service provider may provide each client with a separate individual counseling session. Providing a joint service to two participants and reporting it as two individual services is not permitted.			
	HRM	**MHV**	**SCG, SCI, SCP**
AOD Counseling - Group (P87)	✓	✓	
Mental Health Counseling - Group (P88)		✓	
Treatment Adherence Counseling - Group (P89)		✓	
Group Counseling – Supportive (P91)			✓
Overdose Prevention Training - Group (Q12)	✓		
Seeking Safety - Group (Q14)	✓	✓	✓

Seeking Safety – Group (Q14)		
HRM MHV SCG, SCI, SCP	Payment Processing	The payment unit is the attendee. A maximum of six attendees are payable per session.
	Rules Assessed Automatically That May Make Items Recoupable	Only one Seeking Safety - Group per day per client.