Health Insurance Premium and Cost Sharing Assistance

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:

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

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

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate and allocate funding to Health

Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

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

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

Virginia Ryan White Part B Service Unit Definition:
One medical office visit (**and/or**) lab copayment; cost share for insured client not enrolled in an ADAP insurance-based service option; (**or**) a copayment/cost-share for insured clients for core medical services (e.g., mental health, oral health, substance abuse treatment).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

1.0 Intake and Eligibility

As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications (PCN) on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02
2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).
3. **Residency:** The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Self-referral or referral for Health Insurance Premium and Cost Sharing Assistance Services by a Part B provider is documented prior to initiation of the service.	1.1) Documentation of referral for Health Insurance Premium and Cost Sharing Services is present in the client's record, signed and dated.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined. To be eligible for this service applicants must: a) Be diagnosed with HIV (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third-party payers such as private and commercial insurance plans, and other payers that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures Part B services are used as the payer of last resort and other funding sources must be vigorously pursued. Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities	
Standard	**Measure**
Documentation	
2.1) All Health Insurance Premium and Cost-Sharing Assistance Services provided is documented in client record.	2.1) Documentation of Health Insurance Premium and Cost-Sharing Assistance Services is in client's record signed and dated.
Assessment/Service Plan/Provision of Services	
2.2) An initial assessment of client's core and support service needs to be completed prior to the initiation of the service plan.	2.2) Documentation of assessment in client's record signed and dated.
2.3) Within fifteen (15) days after the initial assessment, a service plan will be developed in collaboration with the insurance assistance staff and client which will identify the scope of insurance services, cost limitations, timeframes, and client responsibilities. The client will be offered a copy of the plan. *Note:* No direct payments will be made to clients.	2.3) Documentation of service plan in client's record signed and dated by the case manager and the client.
2.4) Service plan is reassessed every 90 days to assess status and identify emerging needs.	2.4) Documentation of review and update of the plan as appropriate and signed and dated by staff and the client.
2.5) Assist VDH with the purchase process of health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients.	2.5) Documentation of the health insurance premiums providing the OAHS and pharmacy benefits in client chart.

Note: Purchased health coverage includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents and provides comprehensive primary medical care.	
2.6) Methodology in place to demonstrate purchase of health insurance is cost effective in the aggregate in comparison to the full cost of medications and other appropriate HIV outpatient ambulatory health services.	2.6) Summary of comparative costs.
2.7) Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of eligible clients. *Note:* If funds are used to cover co-pays for prescription eyewear, a physician's written statement confirming the eye condition is related to HIV infection is required.	2.7) Documentation of co-pays and deductibles in client's record.
2.8) Providing funds to contribute to an eligible client's Medicare Part D true out-of-pocked (TrOOP) cost.	2.8) Clients maintain their Medicare Part D coverage and advance through the self-pay/donut hole tier of Part D into the Catastrophic Tier (final tier)
Transition and Discharge	
2.9) Client discharged when Health Insurance Premiums and Cost Sharing Services are no longer needed, goals have been met, upon death, or due to safety issues. (*see 2.10*) <u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with client. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to client's last known address. If client is not present to sign for the letter, it must be returned to the provider. **Exception: If the client has noted during*	2.9) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter*, if applicable. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*

the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary. Documentation: Client's record must include: a) Date services start b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable.	
Transfer: If client transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location.	Discharge summary and other records send with the patient
Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	Document attempts made

Withdrawal from Service: If client reports no longer needing services or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
Case Closure	
2.10) Case will be closed if client: a) Has met the service goals; b) No longer meets eligibility criteria; c) Decides to transfer to another agency;	2.10) Documentation of case closure in client's record with clear rationale for closure.

d) Needs are more appropriately addressed in other programs; e) Moves out of state; f) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; g) Fails to maintain contact with the ADAP staff for a period of three months despite three (3) documented attempts to contact client; h) Can no longer be located; i) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; j) Exhibits pattern of abuse as defined by agency's policy. k) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or l) Is deceased.	

3.0 Client Rights and Responsibilities

Standard	Measure
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering any service because of fact or perception of race,	3.1) Written eligibility requirements and non-discrimination policy on file.

color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	3.2) Written policy on file.
3.3) Provide explanation of *Client's Rights and Responsibilities* to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number; respond to phone calls and mail and • Avoid subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	

4.0 Grievance Process

Standard	Measure
4.1) Grievance policy requires each client to sign & date indicating they have been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g., for persons with disabilities) appropriate to populations served.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, if they have any complaint, or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status, and resolution.
4.4) Review of the grievance policy yearly with client signature.	4.4) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's grievance procedure.
5.0 Personnel Qualifications (including licensure)	
Standard	**Measure**
5.1) All insurance assistance staff will have a a minimum of an associate degree and one year of insurance experience including knowledge concerning COBRA, OBRA, Medicaid, Medicare, and private insurance programs.	5.1) Copy of qualifications in employee personnel file.
5.2) Newly employed insurance personnel must complete orientation within 2 weeks of hire and the following training within 180 days of hire: • HIV 101 • Affordable Care Act • Insurance Marketplace • Medicare Part D • Cultural competency • Legal ramifications, including confidentiality.	5.2) Documentation of training in personnel file.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**

6.1) Health Insurance Premium and Cost-Sharing Assistance Services are culturally and linguistically competent, client-guided and community based. At a minimum, documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual, or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.

7.0 Privacy and Confidentiality (including securing records)

Standard	Measure
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act compliance were applicable.	7.1) Written Client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.
7.3) Store each client's file in a secure location with electronic client records protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access is limited to appropriate personnel.

7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using Health Insurance Premium and Cost Sharing measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Health Insurance Premium and Cost Sharing Assistance services, regardless of age, who will have at least two care markers in a 12-month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program with HIV and receiving Health Insurance Premium and Cost Sharing Assistance, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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