Service Category Definition

Health Insurance Premium and Cost-sharing Assistance provides financial assistance for copayments (including co-payments for prescription eyewear for conditions related to HIV/AIDS), and deductibles. These monitored short-term payments are limited in amounts and periods of time.

Service Category Definition (HIV/AIDS BUREAU POLICY PCN #16-02)

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

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

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

- HRSA RWHAP Part A 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 Parts C or 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.

Intake and Eligibility (HIV/AIDS BUREAU PCN #13-02)

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

REQUIRED DOCUMENTATION TABLE

Eligibility Requirement	Initial Eligibility Determination & Once a Year/12 Month Period Recertification	Recertification (minimum of every six months)
HIV Status	• Documentation required for Initial Eligibility Determination • Documentation is not required for the once a year/12-month period recertification	No documentation required
Income	Self-attestation form for recertification ONLY	• Recipient may choose to require a full application and associated documentation **OR** • Self-attestation of no change • Self-attestation of change - Recipient must require documentation of change in eligibility status
Residency	Self-attestation form	• Recipient may choose to require a full application and associated documentation **OR** • Self-attestation of no change • Self-attestation of change - Recipient must require documentation
Insurance Status	Recipient must verify if the applicant is enrolled in other health care coverage and document status in the client's chart	• Recipient must verify if the applicant is enrolled in other health coverage **OR** • Self-attestation of no change • Self-attestation of change - Recipient must require documentation
Viral Load	Documentation of viral load count	Documentation of viral load count

All agencies are required to have a client intake and eligibility policy on file that adheres to the EMA's eligibility policy. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A Eligibility Policy in accordance with HRSA/HAB regulations. Eligibility must be completed at least once every six months.

Eligible clients in the New Haven & Fairfield Counties EMA must:

- Live in New Haven or Fairfield Counties in Connecticut;
- Have a documented diagnosis of HIV/AIDS;
- Have a household income that is at or below 300% of the federal poverty level; and
- Be uninsured or underinsured.

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

Personnel Qualifications (including licensure)

None

Care and Quality Improvement Outcome Goals

Provision of Health Insurance Premium and Cost Sharing Assistance that provides a cost-effective alternative to ADAP by:

- Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection)
- Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection.
- Clients' low-income status as defined by the EMA or State Ryan White Program is clearly indicated in the clients' files for eligibility
- 100% of clients access HIV-related PMC or HIV medications supported by co-payment assistance.

Service Standards and Goals

HRSA/HAB National Program Monitoring Standards for RWHAP Part A: Section B: Core Medical Services		GOAL
STANDARD/MEASURE	**AGENCY RESPONSIBILITY**	
Documentation of an annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles for eligible low income clients compared to the costs of having the client in the Ryan White Services Program.	Conduct an annual cost benefit analysis (if not done by the Recipient) that addresses noted criteria.	100%
Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications.	Where premiums are covered by Ryan White funds, provide proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications.	100%
Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection.	When funds are used to cover co-pays for prescription eyewear, provide a physician's written statement that the eye condition is related to HIV infection.	100%
Assurance that any cost associated with liability risk pools or Social Security is not being funded by Ryan White.	Provide documentation that demonstrates that funds were not used to cover costs of liability risk pools, or social security.	100%

New Haven/Fairfield Counties EMA RWHAP Part A Program Monitoring Standards for Health Insurance Premium Cost Sharing Assistance		GOAL
STANDARD/MEASURE	**AGENCY RESPONSIBILITY**	
Provider agency has clearly stated, written guidelines that list all criteria, including allowable extenuating circumstances, used to determine if a client is eligible for health insurance premium or cost-sharing.	Agencies have written guidelines for health insurance premiums and/or cost sharing assistance.	100%
Agency provides comprehensive orientation for new staff members to ensure that staff is fully trained to implement the written guidelines and follows written guidelines, without exception, for all requests.	Documentation that new staff receives orientation on written guidelines and follows written guidelines, without exception, for all requests.	100%
Services are made available to all individuals who meet HIPCSA program eligibility requirements.	Charts document client eligibility for Part A assistance.	100%
Agency follows written guidelines, without exception, for all requests.	Charts document adherence to written guidelines.	100%
Provider agency pays co pay requests for payment within 7 business days of receipt of bill	Charts document non-urgent payment is processed within 7 business days.	100%
Agency sends notice to case manager that payment has been made within 7 business days after check is sent.	Client case managers receive notice of payment within 5 business days after check is sent and is documented in chart.	100%

Clients Rights and Responsibilities

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

Client Charts, Privacy, and Confidentiality

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of the client's Personal Health Information (PHI). Agencies must have a client's release of information policy in place and review the release regulations with the client before services are provided. A signed copy of the client's release of information must be included in the client's chart.

Cultural and Linguistic Competency

Agencies providing services must adhere to the National Standards on Culturally and Linguistically Appropriate Services. (please see https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53 for more information)

Client Grievance Process

Each agency must have a written grievance procedure policy. Clients will be informed and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of receipt of the grievance procedure policy form must be included in the client's chart.

Case Closure Protocol

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