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SERVICE STANDARDS FOR Health Insurance Premium & Cost-Sharing Assistance (HIPCA)

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I. PURPOSE OF SERVICE STANDARDS

The purpose of these service standards is to define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Newark Eligible Metropolitan Area (NEMA)[1] such that the clients of this service receive the same quality of service regardless of where or by whom the service is provided. Standards will be used as contract requirements, in program monitoring, and in quality management.

II. GOAL

The goal of Health Insurance Premium & Cost-sharing Assistance (HIPCA) is to foster medical adherence by addressing financial barriers in accessing and continuing medical care for People Living with HIV/AIDS (PLWHA).

III. DEFINITION

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

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

To use 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.

IV. KEY SERVICE COMPONENTS AND ACTIVITIES

Newark EMA Ryan White HIV/AIDS Program funds may be used to cover the cost of private health insurance deductibles and co-payments to assist eligible low-income clients in maintaining health insurance or receive medical benefits under a health insurance or benefits program.

- Newark EMA Ryan White HIV/AIDS Program funds may NOT be used to cover premiums to purchase and maintain health insurance. For premium assistance, please refer the client to the New Jersey Health Insurance Continuation Program (***HICP***) or the New Jersey Pilot Health Insurance Premium Program.

Grantees and their sub-recipients are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services. Grantees and sub-recipients must assure that individual clients are enrolled in health care coverage whenever possible or applicable and are informed about ACA and the consequences for not enrolling. Please note that the RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans. *(See HRSA Policy notice 13-03 Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post-Implementation of the Affordable Care Act)*

V. INDICATORS/PERFORMANCE MEASURES

Documentation of clients' income eligibility as defined by the Newark EMA.
Documentation of adherence with medical care plan.
Documentation that supports the service is being provided as a result of financial need.
Documentation of an annual cost-benefit analysis illustrating the greater benefit in paying for co-pays and/or deductibles for eligible low-income clients, compared to the cost of having the client in the Ryan White Services Program.
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.
Assurance that Ryan White funds are not being used to cover costs associated with Social Security.

VI. PROVIDER AGENCY POLICIES AND PROCEDURES

A. Agency must be licensed and/or accredited by the appropriate city/county/state/federal agency.
B. Staff must meet minimum qualifications detailed in the job description and service standards.
C. Services will be provided through the facility or through a written affiliation agreement.

D. **Records Retention** – Policies must exist for the production, maintenance, and retention of client clinical records. The agency will keep inactive client records in a confidential locked location. Client records will be kept for seven (7) years.
E. **Confidentiality Policy** - All medical case managers must assure the client that information provided by the client or information obtained on behalf of the client is confidential. All written and verbal communications regarding the client will be maintained with strict confidentiality according to the policy of the agency and in accordance to HIPAA requirements.
F. There will be a private confidential office space for seeing clients.
G. **Cultural and Linguistic Competence** - Agency will ensure that culturally and linguistically appropriate services are available and be able to provide services that are culturally sensitive and in the client's preferred language or arrange for a competent interpreter.
H. **Americans Disabilities Act Compliance** – The agency must demonstrate that the needs of disabled clients are met.
I. **Client consent** – Written consent must be obtained to release/exchange client information. The consent must be specific as to type of information, agency to which the information will be shared, and length of time during which the consent is valid. The client must be notified of the release of information.
J. **Grievance Policy** -The medical case manager must review the policy with the client and provide a copy in a language and format the client can understand.
K. The Agency must have a written **Emergency Plan** which includes procedures for fire, bomb threat, evacuation, accidents, and natural disasters.
L. Service providers should receive continuing education in relationship to HIV, substance abuse, mental health, co-occurring disorders, health, and related subjects such as "Prevention with Positives".
M. A **Quality Assurance Plan** shall be developed for patient care which is specific to case management. This plan shall be reviewed annually.
N. Agencies must maintain linkages among other agencies to better coordinate service provision.
O. The agency must demonstrate input from clients via a client satisfaction survey or similar method.

VII. ACCESSIBILITY/STANDARDS OF SERVICE

A. There will be no barriers due to client disability. The Agency must comply with ADA requirements for the provision of reasonable accommodations to address clients with special needs.
B. The agency must demonstrate a commitment to provide services that are culturally sensitive and linguistically appropriate.
C. There will be no barriers due to language differences between medical case manager and clients. Agencies must have the ability to provide native language speakers for services when twenty percent (20%) or more of their clients prefer another language or arrange for a competent interpreter.

VIII. CLIENTS RIGHTS AND RESPONSIBILITIES

A. Agencies funded to provide HIPCA services through medical case management shall have the ability to provide service in the client's native language when twenty percent (20%) or more of their clients prefer another language and must provide information for clients in appropriate languages or arrange for a competent interpreter.
B. All written materials should be printed in a language that is understandable to the client and should be written at no higher than a 5th grade level.
C. The agency will have a Clients Rights Statement posted and available to the client upon request. This will be in the client's language or explained to the client in the client's preferred language.
D. The agency will have a Consent for Services and Release of Records Form, which is dated and time limited, signed by the client or person legally able to give consent. This form will be signed by the client

after reviewing the initial "Service Plan" and when the client is reassessed and/or when the plan is updated or changed.

E. The agency will have a written policy related to Client Grievance Procedures which is reviewed with the client in a language and format the client can understand.

F. The agency will have a written Client Confidentiality Policy in conformance with State and Federal Laws.

G. All new clients will receive HIV/AIDS orientation and be provided with educational materials in their native language, when possible, and in a culturally appropriate manner.

H. Clients have the right to refuse services.

IX. PROCESS

A. Client Eligibility Determination and Initial Certification
B. Intake
C. Client Assessment
D. Service Plan
E. Re-certification (every six months)
F. Re-assessment
G. Case Closure/Discharge
H. Case Transfer; when appropriate

A. Client Eligibility Determination and Initial Certification – To determine client eligibility for Ryan White Services. Documentation is required.

1. Proof of HIV+ status to determine eligibility for Ryan White Part A funding.
2. Summary of medical benefits/insurance
3. Verification of insurance status
4. Employment status
5. Verification of income/gross annual income (must be less than or equal to 500% of the Federal Poverty Level [FPL])
6. Living arrangements/ Household size
7. County of residence

B. Intake - Completed prior by the Medical Case Manager. (See Medical Case Management Service Standards)

C. Client Assessment - Conduct an evaluation and assessment to determine the financial need. The assessment will include the following:

1. Client income
2. Review of all other potential payment resources
3. Cost of co-pays
4. Cost of deductibles

D. Service Plan

1. Provision of HIPCA services must be added to existing Medical Case Management Care Plan by the Medical Case Manager.

E. Re-certification – To maintain eligibility for Ryan White services, the client (while active), must be re-certified at least every six months to ensure that an individual's residency, income, household

size, and insurance statuses continue to meet Grantee eligibility requirements and to verify that Ryan White is the payer of last resort.

1. After initial certification, the bi-annual certification will be self-reported by the client.
2. The annual re-certification must be supported by documentation provided by the client.

F. Re- assessment – The client plan for co-pay and/or deductible assistance through HIPCA services will be reviewed at least once every six months while the client is active.

G. Case Closure/Discharge

1. The Medical Case Manager must document date and reasons for closure of HIPCA Services. Reasons for case closure/discharge may include, but are not limited to: no contact, client request, client moves out of service area, client died, and client ineligible for services.
2. A summary of the financial services received by the client must be documented for the client's record.

H. Case Transfer

1. The Medical Case Manager should facilitate the transfer of client records/information, when necessary.
2. The client must sign a consent form to transfer records which is specific and dated.

X. ADDITIONAL SERVICE STIPULATIONS

1. Funds may only be used to cover the cost of deductibles and co-payments.
2. Funds may not be used to pay costs of liability risk pools or social security or premiums.
3. All payments will be made directly to the providers. No direct payments will be made to clients.
4. Assistance with paying the clients' out of pocket costs for laboratory and diagnostic testing will be funded under Primary Medical Care – sub-type Laboratory/Diagnostic testing – and must NOT be charged to HIPCA.

XI. Program Guidance [HIV/AIDS Bureau Policy 16-02]

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.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance