Ryan White Part B
Health Insurance Premium and Cost-Sharing Assistance (HIPCSA)
Service Standard

Definition

Health Insurance Premium and Cost-Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, co-insurance, co-payments, and deductible amounts. Examples of allowable services billed to Health Insurance Premium & Cost-Sharing Assistance include copayments for medications not covered by the ADAP formulary, mental health co-payments, etc.

Purpose

To provide financial assistance for eligible individuals living with HIV to maintain a continuity of care.

Unit of Service

A "Service unit" of Health Insurance Premium & Cost-Sharing Assistance is documented per service provided (i.e., one payment equals one service unit) as "Health Insurance Premium & Cost-Sharing Assistance" in CAREWare, with a corresponding dollar amount.

Key Activities

- Eligibility/Assessment
- Provision of Services
    - Paying for medication
    - Paying for health insurance
    - Cost-sharing assistance
- Ensuring payor of last resort
- Expenditure monitoring
- Records management

Program Guidance

- The RWHAP, as the *payor of last resort* will continue to fund RWHAP services not covered, or partially covered, by public or private health care coverage. RWHAP recipients and subrecipients should consider assisting individual clients by paying for premiums and/or cost sharing, if cost effective.

- RWHAP funds may be used to pay for Medicare premiums and cost sharing associated with Medicare Parts B (medical insurance), C (Medicare Advantage Plans) and D (medication coverage), when doing so is determined to be cost effective in the aggregate and includes coverage for both outpatient/ambulatory health services and prescription drug coverage that includes at least one drug in each class of core antiretroviral therapeutics.
- Client agrees to participate in insurance option that best meets her/his medical needs and for which the client is eligible.
- For additional general program guidance, along with guidance for specific types of health care coverage, please consult Policy Clarification Notice (PCN) 18-01: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/18-01-use-of-rwhap-funds-for-premium-and-cost-sharing-assistance.pdf

1.0 Eligibility Determination

(HRSA/HAB DMHAP and DSHAP National Monitoring Standards-Universal-Part A & B April 2013 Section B)

- Eligibility determination process requiring documentation in patients' records of low-income status and eligibility based on a specified percent of the FPL and proof of an individual's HIV-positive status, and residency
- Determination and documentation of patient eligibility every six months

Standard	Measure	Documentation
1.0 Eligibility screening and to be completed within 15 days of initial contact with client	1.0. Intake is documented to occur within the 15 days	1.0 Intake and eligibility screening, signed and dated by the provider, in client file.
1.1 Eligibility for HIPSCA services for HIV positive persons will include: • HIV diagnosis • Montana residency • Income < or = to 500% of FPL	1.1.a. Client has proof of eligibility requirements. 1.1.b. Client reports any changes to these criteria	1.1.a. Client's HIV diagnosis, Montana residency, and proof of low income (most current 1040 tax return) included in client file 1.1.b. Any changes to client's residency, income and/or insurance coverage in client file
1.3 Client must be certified every six months to continue to receive Ryan White services. There is no grace period.	1.3 Recertification is completed by provider every six months.	1.3 Signed and dated recertification in client file

2.0 Provision of Services

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes out-of-pocket costs, such as premium payments, co-payments, coinsurance, and deductibles. The cost of insurance must be lower than the cost of providing health services through grant-supported direct delivery, including costs for participation in the Montana Ryan White AIDS Drug Assistance Program (ADAP).

Standard	Measure	Documentation
2.1 Providers who do not provide health insurance premium and cost sharing assistance should systematically provide access to services.	2.1 Provider will initiate referrals as agreed upon by the client and provider.	2.1 Signed and dated case notes in client care plan/file
2.2 Providers will ensure that service funding will be available throughout the year	2.2.a. Monitoring/managing of expenditures to ensure expenses do not surpass approved budget amount 2.2.b. Tracking utilization of assistance	2.2.a. Mechanism in place to track expenses 2.2.b. Case notes and client care plan
2.3 Providers may purchase health insurance (both job or employer-related plans and plans on the individual and group market) that provides comprehensive primary care and pharmacy benefits for clients that provide a full range of HIV medications.	2.3., 2.4., 2.5, and 2.6 In compliance with requirements describe in HRSA Policy Clarification Notice (PCN) 16-02	2.3, 2.4., 2.5, and 2.6 HRSA PCN 16-02 on file
2.4 Providers may purchase stand-alone dental insurance premiums when cost effective and/or cost sharing assistance.		
2.5 Provider may contribute to a client's Medicare Part D true out-of-pocket costs.	Follows requirements stated in Medicare Part D program guidance above.	

3.0 Expenditure Monitoring

Purpose
Health Insurance Premium & Cost-Sharing Assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded agencies must be able to track the total amount of Health Insurance Premium & Cost-Sharing Assistance funding provided.

Standard	Measure	Documentation
3.1 Providers will effectively utilize and allocate expenditures	3.1.a. Procedure to monitor/manage expenditures of Health Insurance Premium & Cost-Sharing that ensures funding will be available throughout the program year 3.1.b. Tracking utilization of assistance. 3.1.c. Tracking of funds to ensure the total combined amount per client must not exceed the determined award/budgeted amount per contract year.	3.1.a., b., and c. Expenditures are entered into CAREWare or other tracking system
3.2 No payment may be made directly to clients, family, or household members.	3.2 Provide mechanism through which payment can be made on behalf of the client.	3.2 Provider will maintain documentation ensuring payments were made to appropriate vendors in client files.

4.0 Records Management

Standard	Measure	Documentation
4.1 Records will reflect compliance with the Health Insurance Premium and Cost-Sharing Assistance standards and program guidance (above). Records should be	4.1 Providers of Health Insurance and Premium and Cost-Sharing Assistance will maintain records for each client served.	4.1 Health Insurance Premium and Cost-Sharing records include: • Proof of eligibility criteria in client file • Date(s) client received assistance in client file

complete, accurate, confidential, and secure.		• Copy of payment ledger in agency's files.

5.0 Transition and Discharge

Standard	Measure	Documentation
5.1.a. Client is discharged when HIPCSA services are no longer needed, goals have been met, upon death, or due to safety issues. 5.1.b. Prior to discharge: Reasons for discharge and options for other service provision should be discussed with client. Whenever possible, discussion should be occurring 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. 5.1.c. If client transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records. If client moves to another area,	5.1.a. Discharge plan and summary, including notes regarding attempt(s) to notify the client occur within 30 days of discharge 5.1.b. Summary of the date services began, any special client needs, services needed/actions taken, if applicable, date of discharge, reason(s) for discharge, and referrals made at time of discharge, if applicable 5.1.c. Discharge summary, any referrals made by transferring agency, and other requested records must be provided within five business days of request.	5.1.a. Discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. 5.1.b. Client's record must include: Date services began Special client needs Services needed/actions taken, if applicable Date of discharge Reason(s) for discharge Referrals made at time of discharge, if applicable 5.1.c. Summaries, referrals and all other records located in client file

transferring agency will make referral for needed services in the new location.		

<u>6.0 Case Closure</u>

Standard	Measure	Documentation
6.1 Case will be closed if client: • Has met the service goals • Decides to transfer to another agency • Needs are more appropriately addressed in other programs • Moves out of state • Fails to provide updated documentation of eligibility status; thus, no longer eligible for services • Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact client • Can no longer be located • Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan	6.1 Client case is closed, with provider notes explaining the reasons(s) for closure.	6.1 Signed and dated description of case closure, documenting clear rationale for closure, in client file. May include: • Can no longer be located • Withdraws from or refuses funded services • Reports that services are no longer needed, or no longer participates in the individual service plan • Exhibits pattern of abuse as defined by agency's policy • Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program • Is deceased.

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7.0 Staff Qualifications
(HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B, Section C)

Standard	Measure	Documentation
7.1 Medical Case Managers (MCMs) must have a minimum of a B.A. in Social Work (BSW), M.A. in Social Work (MSW)—licensure preferred, or other related health or human service degree from an accredited college or university; or current MT-licensed Registered Nurse (RN) and an Association of Nurses in AIDS Care (ANAC) Certification (preferred); or related experience for a period of two years, regardless of academic preparation.	7.1.a. If licensed, a copy of the most current Montana license must be kept in the Medical Case Manager's personnel file. 7.1.b. Copies of degrees and/or certifications, demonstrating appropriate education and training.	7.1. a. and b. Copies of degrees, certifications and/or licenses (as applicable) in personnel file.
7.2 All Medical Case Managers must complete a minimum training regimen within one year of their hire date that includes: (a) HIV	7.2 Copies demonstrating completion of required trainings Note: If newly hired Medical Case Managers have previously obtained all the	7.2 Dated documentation of required/additional training should be kept in the Medical Case Manager's personnel file.

Case Management Standards, (b) Counseling, Treatment and Referral Services (CTRS) training to include HIV disease processes, treatment, testing, legal ramifications to include confidentiality, counseling/referral and prevention, (c) cultural competency and (d) AIDS Drug Assistance Program (ADAP)/Insurance training.	required training, they do not need to repeat it.	
7.3 All Medical Case Managers, except Montana Licensed Clinical Social Workers (LCSW), Licensed Clinical Professional Counselors (LCPC) or nationally Certified Case Managers (CCM) must complete an MT DPHHS-approved basic case management training program within one year of their hire date [e.g. Mountain West AIDS Training Center (MWAETC) offers a variety of trainings and consultation services.	7.3. and 7.4 Documents that demonstration completion of training(s)	7.3. and 7.4 Dated documentation of completion applicable training(s) in the Medical Case Manager's personnel file.
7.4 All Medical Case Managers are recommended to complete 12 hours of continuing education in HIV/AIDS each year. Appropriate continuing education opportunities will be identified by Case Managers.		

8.0 Grievance Policy

Purpose
To ensure that consumers may voice a complaint or grievance.

Procedures
All Ryan White providers must have a grievance policy that is posted in the facility. Additionally, all clients will receive a copy of the grievance procedure. The first step in filing a grievance is with the *agency providing the service*. Consumers may voice a complaint or grievance to their Case Manager. Clients are expected to attempt resolution at the local level. If, however, clients are unable to resolve the issue, they may pursue a second step—filing a grievance with the State Health Department. Within 30 days of the local determination, consumers may file the complaint or grievance in writing (See Appendix A for sample form) to:

Montana DPHHS
HIV/STD Program, Ryan White Part B
Attn: HIV Treatment Coordinator
1500 E. Broadway
Room C-211
Helena MT 59601

An applicant may submit a complaint on the following grounds:
- The client believes the sub-recipient is not treating them fairly.
- The client believes the sub-recipient is not providing quality services.
- The client was denied services.

The applicant (client) must state all the facts and arguments for the appeal in the form provided (Appendix A), to include detailed descriptions of the action the client is appealing and the relief or correction the applicant is requesting. The form *must* be signed by the client.
The Ryan White Part B Program Manager will respond in writing within 15 days of receipt of the grievance or complaint informing the client of the time and place of a meeting with the Ryan White Part B Program Manager and other appointed HIV/STD state staff.

Standard	Measure	Documentation
8.1.a The Grievance Policy has been explained to each client. Clients may file a grievance if their request for services is denied or if they have any complaint or concern about the services received.	8.1.a. and b. Each client is given a copy of the Grievance Policy to sign, indicating understanding of the reasons for filing a grievance, as well as the process for doing so.	8.1.a. Written Grievance Policy on file.

8.1.b. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines.		8.1.b. Policy is available in languages and formats appropriate to populations served.
8.2 Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	8.2 Various formats available	8.2 Policy and various formats on file at the agency.

9.0 Cultural and Linguistic Competency
The National Standards on Culturally and Linguistically Appropriate Services (CLAS) require agencies to make available easily understood patient-related materials. Providers must post signage in the languages of the commonly encountered group(s) represented in the service area.

Purpose
Providers will reduce barriers to care or increase access to care through the provision of culturally and linguistically appropriate services.

Standard	Measure	Documentation
9.1 Health services are culturally and linguistically competent, client-guided and community based.	9.1.a. Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; 9.1.b. Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; 9.1.c. List of cultural competency trainings completed by staff.	9.1.a. and b. Notes regarding staff cultural and linguistic experience/competence 9.1.c. Completed trainings documentation in personnel files.

9.2 Each provider shall make available to clients the process for requesting interpretation services, including American Sign Language	9.2 Interpreter(s) is/are available.	9.2 A list of interpreters on file.

10.0 Client Rights and Responsibilities

(National Monitoring Standards: Provision of Part B-funded HIV primary medical care and support services, to the maximum extent, without regard to either: the ability of the individual to pay for such services, or the current or past health conditions of the individuals served.)

Standard	Measure	Documentation
10.1.a. Services are available and accessible to any individual who meets program eligibility requirements. 10.1.b. All providers shall comply with all applicable federal, state, and local anti- discrimination laws and regulations, including but not limited to the American's with Disabilities Act. 10.1.c. All providers shall adopt a non-discrimination policy prohibiting based on the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or AIDS/HIV.	10.1 Providers are aware of eligibility requirements and non-discrimination policies.	10.1 Written eligibility requirements and non-discrimination policy on file.
10.2.a. Client's Rights and Responsibilities policy is explained to client.	10.2.a. Clients sign and date a copy of the policy.	10.2.a. Written policy on file.

10.2.b. A copy of Client's Rights and Responsibilities is provided 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; All records treated confidentially Have information released only when: A written release of information is signed; A medical emergency exists; There is an immediate danger to the client or others; There is possible child or elder abuse	10.2.b. Current Client's Rights and Responsibilities form signed and dated by client, indicating the client's understanding of her/his rights and responsibilities.	10.2.b. Signed copy located in client's record.

<u>11.0 Secure Client Records, Privacy, and Confidentiality</u>

Standard	Measure	Documentation
11.1 Client confidentiality is ensured	11.1.a. Client confidentiality policy that includes a Release of Information (ROI) 11.1.b. Health Insurance Portability and Accountability Act (HIPPA) compliance	11.1.a. Written client confidentiality policy on file at provider agency

		11.1.a.HIPPA documentation is on file and posted where clients can view it.
11.2 Client's consent for release of information is determined.	11.2 Current Release of Information Form signed and dated by client and provider representative	11.2 Signed and dated ROI located in client file. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months.
11.3 Electronic patient records are protected from unauthorized use.	11.3 Each client file is stored in a secure location.	11.3.a. Files stored in locked file or cabinet with access limited to appropriate personnel. 11.3.b. Electronic files are password protected with access limited to appropriate personnel.
11.4 Annual submission of Verification of Receipt of Assurance of Key Requirements	11.4 All staff that handle client-identifying information document	11.4 Signed Verification of Receipt of Assurance of Key Requirement forms on file

12.0 Quality Management

National Monitoring Standards: Implement a Clinical Quality Management Program (CQM) to include: a) written QM plan; b) quality expectations for providers and services; c) method to report and track expected outcomes; d) monitoring of provider compliance with HHS treatment guidelines and Part B Program's approved Standards of Care.

Measure and report client health outcomes using ADAP measures approved by MT DPHHS

- HIPCSA clients receiving medications or medication co-payments and/or deductibles will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
- 80% of clients are linked to medical care as documented by at least two medical visits, viral load or CD4 test reported in the measurement year.