HEALTH INSURANCE PREMIUM COST SHARING ASSISTANCE SERVICE STANDARD

Service Category Definition (approved by SPA June 2021)

Health Insurance Premium and Cost-sharing Assistance provides financial assistance for co-payments (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.

Intake and Eligibility (HIV/AIDS BUREAU PCN #21-02)

For both initial/annual and six-month recertification procedures, eligibility determinations may be performed simultaneously with testing and treatment. Recipients and subrecipients 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 ELIGIBILITY DOCUMENTATION TABLE

Eligibility Requirement	Initial Eligibility Determination	Recertification Once a Year/12 Month Period
HIV Status	Documentation required for Initial Eligibility Determination: • Confirmatory lab results • Lab results (including VL/CD4) • Lab request form signed by provider	No documentation required
Income	Documentation required for Initial Eligibility Determination: • Paystubs • SSI, SSDI and DSS income determination forms • Zero income affidavit • Bank Statement • Self-Employment Letter	• Recipient may choose to require a full applicationand associated documentation **OR** • Self-attestation of no change • Self-attestation of change - Recipient must require documentation of change in eligibility status
Residency	Documentation required for Initial Eligibility Determination: • Driver's License/ID • Utility Bill • Medical Bill • Bank Statement • Landlord Letter-Notarized • Copy of Lease/Mortgage • Letter from Shelter • Official Correspondence	• Recipient may choose to require a full applicationand associated documentation **OR** • Self-attestation of no change • Self-attestation of change - Recipient must require documentation of change in eligibility status

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.

Services will be provided to all clients without discrimination based on: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, prior medical history, or any other basis prohibited by law.

Guidance on Complying with the Payor of Last Resort Requirement:

- RWHAP Recipients and Subrecipients must ensure that reasonable efforts are made to use non RWHAP resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify any other possible payors to extend finite RWHAP funds.
- RWHAP Recipients and Subrecipients must maintain policies and document their efforts to ensure that they assist clients to vigorously pursue enrollment in health care coverage and that clients have accessed all other available public and private funding sources for which they may be eligible.
- RWHAP Recipients and Subrecipients can continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage so long as there is rigorous documentation that such coverage was vigorously pursued.
- RWHAP Recipients and Subrecipients should conduct periodic checks to identify any potential changes to clients' healthcare coverage that may affect whether the RWHAP remains the payor of last resort and require clients to report any such changes.

Payor of Last Resort:

Once a client is eligible to receive RWHAP services, the RWHAP is considered the payor of last resort, and as such, funds may not be used for any item or service to the extent that payment has been made, or can reasonably be expected to be made under:

1. Any State compensation program
2. An insurance policy, or under any Federal or State health benefits program
3. An entity that provides health services on a pre-paid basis

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, prior medical history, or any other basis prohibited by law.

Personnel Qualifications (including licensure)

None

Care and Quality Improvement Outcome Goals

Program Outcome:

- 90% of clients are virally suppressed as evidenced by the last viral load test within the measurement year (<200 copies/mL) as documented in the reporting system.

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. Remove unless standard to keep all HRSA/HAB measures in SS	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%
Provider 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%
	Provider Agency follows written guidelines, without exception, for all requests.	Charts document adherence to written guidelines.	100%
	Provider agency processes co-pay and/or deductible requests for payment within 7 business days of receipt of bill from client.	Charts document non-urgent payment is processed within 7 business days.	100%
	Provider Agency sends notice to case manager that payment has been sent within 7business days.		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.