Health Insurance Premium and Cost Sharing Assistance

SERVICE CATEGORY DEFINITION

Health Insurance Premium and Cost Sharing Assistance (HIPCSA):

Provision of 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. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP Part A recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part A recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services
- RWHAP Part A recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

The service provision consists of either or both 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
- Paying cost-sharing on behalf of the client

HIPCSA programs must document a process for payment of insurance premiums deductibles, and co-payments as well as prescription co-payments that include the following:

- Documenting cost/benefit analysis of insurance plan
- Verifying health insurance coverage of medication for HIV/AIDS is reasonable compared to coverage and cost funded by the Ryan White Part A services
- An accounting system to ensure timely payments of premiums to avoid policy cancelation
- Process to determine when established limits of funds and time have been met for each client
- Process to ensure policy and payments are paid on behalf of client only

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is between **301% and 500**% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified 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.

Health Insurance Premium and Cost Sharing Assistance:

PERSONNEL QUALIFICATIONS

Health Insurance Premium and Cost Sharing Assistance (HIPCSA) providers must:

- Be knowledgeable and comply with all applicable federal, state, local, and Cleveland TGA program and contractual requirements.
- Have a documented process for payments under the program, which may include insurance premiums, deductibles, and co-payments, as well as prescription co-payments.
- Maintain adequate linkages with health insurance providers needed for the reimbursement of co-payments in a timely manner.
- Ensure that all HIPCSA funded staff receive orientation training on the agency's internal HIPCSA guidelines.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of the Health Insurance Premium and Cost Sharing Assistance program is to assist client in maintaining health insurance and/or benefits that will enable medical adherence and stability in care.

Clinical quality improvement outcome goals for Health Insurance Premium and Cost Sharing Assistance are:

- 80% of client files include documentation of cost benefit analysis of insurance plan.
- 80% of clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Health Insurance Premium and Cost Sharing Assistance:

SERVICE STANDARDS

	Standard	Measure	Goal
1	* Agency has written guidelines for implementing Health Insurance Premium and Cost Sharing Assistance program.	* Written agency guidelines are reviewed.	100%
2	* All new agency staff receive orientation to agency's HIPCSA guidelines.	* Orientation documentation reviewed.	100%
3	Client file contains documentation of annual cost benefit analysis that addresses noted criteria.	Documentation of annual cost benefit analysis evident in client chart.	80%
4	Where premiums are covered, client file includes proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications.	Documentation of comprehensive primary care and HIV medication coverage evident in client chart.	80%
5	Where covering co-pays for prescription eyewear, the client file includes physician's written statement that the eye condition is related to HIV infection.	Documentation of physician's written statement evident in client chart.	80%
6	* Client file includes documentation that provider paid request for payment within 10 business days.	* Documentation of payment date evident in client chart.	80%
7	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report)	80%
8	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

* Indicates local TGA Standard of Care
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Health Insurance Premium and Cost Sharing Assistance:

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 understands fully his or her rights and responsibilities.

CLIENT RECORDS, 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 consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies providing services must adhere to the National Standards on Culturally and Linguistically Appropriate Services.

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Appendix A: Allowable and Unallowable Services

ALLOWABLE SERVICES

Allowable Services Include:

- Payments of insurance premiums to the insurance carrier or its designated agent
- Payment or related co-pays and/or deductibles
- Co-payments for prescriptions on LPAP formulary
- Payment of three-month prescription co-pays from mail-order pharmacies, where cost effective or required by insurance plan
- Payment of client's tax liability associated with a client's receipt of too much advances premium tax credit, if the grantee purchased insurance for the client through the Marketplace.

UNALLOWABLE SERVICES

Unallowable Services Include:

- Any duplication of services provided by the Ohio Department of Health Ryan White Part B Program
- Co-payments, co-insurance or deductible costs associated with hospitalization and/or emergency room care
- Direct payments to clients
- Out of network expenses without prior approval of the provider. Services must be unavailable or only partially available in network
- Payments for services/medications rendered that are not covered or are denied by the primary insurance carrier

Appendix B: Client Eligibility

CLIENT ELIGIBILITY

To be eligible for Health Insurance Premium and Cost Sharing Assistance a client must:

1. Have no other third-party payer
2. Establish eligibility for Ryan White services as defined in the Cleveland Eligibility policy.
3. Adhere to all program requirements and furnish in a timely manner all information needed to provide services, including as applicable:
    - Premium amount
    - Name of plan
    - Address where premium payments are to be mailed
    - Proof of payment of client's portion of premium to provider prior to provider paying portion

Clients who are purchased or are purchasing Marketplace insurance must:

1. Purchase a Gold Level plan if income is 401% -500% FPL or if income is 301% -399% and client is ineligible for cost sharing;
2. Purchase Silver Level plan if income is 301% -399% and client is eligible for cost-sharing assistance;
3. Take cost-sharing subsidies/full advance premium tax credit in advance (at plan enrollment);
4. Provide insurance eligibility notice or explanation of benefits;
5. File federal taxes in the year in which advances premium tax credit is received;
6. Provide federal tax return information during the reconciliation process to determine ongoing program eligibility and whether the client will be receiving refunds for overpayment of advance premium tax credits;
7. Report changes in household income size and income to the Marketplace throughout the year.