DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Health Insurance Premium & Cost Sharing Assistance (HIPCA)

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC EMA such that clients of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all clients and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Health Insurance Premium and Cost Sharing Assistance (HIPCA) 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 RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), a RWHAP recipient must implement a methodology that incorporates the following requirements:

- RWHAP 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 recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV

outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate, and allocate funding to HIPCA only when determined to be cost effective.

To use RWHAP funds for standalone dental insurance premium assistance, a RWHAP recipient must implement a methodology that incorporates the following requirement:

- RWHAP 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 purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to HIPCA on when determined to be cost effective.
- Key Services Components and Activities
  Provision of Health Insurance Premium and Cost-sharing Assistance that provides a cost - effective alternative to ADAP by: a) Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low income clients that provide a full range of HIV medications , b)Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the client , c)Providing funds to contribute to a client's Medicare Part D true out-of-pocked (TrOOP) costs.

II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White clients to maintain proof of eligibility annually. Supporting documentation is required to demonstrate client eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.
2. **Residency:** The following are acceptable methods of meeting the burden for residency:
   - Current lease or mortgage statement
   - Deed settlement agreement
   - Current driver's license
   - Current voter registration card
   - Current notice of decision from Medicaid
   - Fuel/utility bill (past 90 days)
   - Property tax bill or statement (past 60 days)
   - Rent receipt (past 90 days)
   - Pay stubs or bank statement with the name and address of the applicant (past 30 days)
   - Letter from another government agency addressed to applicant
   - Active (unexpired) homeowner's or renter's insurance policy
   - DC Healthcare Alliance Proof of DC Residency form

- If homeless, a written statement from case manager or facility

2. **Income:** Client income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:
   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the applicant projecting current annual income must be included
   - Copy of the tenant's lease showing client as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

Assessment/Service Plan/Provision of Services	
An initial assessment of client's core and support service needs to be completed prior to the initiation of the service plan.	Documentation of assessment in client's record signed and dated.
Within fifteen (15) days after the initial assessment, a service plan will be developed in collaboration with the insurance assistance staff and client which will identify the scope of insurance services, cost limitations, timeframes and client responsibilities. The client will be offered a copy of the plan. The provision of HIPCA services can be added to an existing service plan *Note:* No direct payments will be made to clients.	Documentation of service plan in client's record signed and dated.
Service plan is reassessed every 90 days to assess status and identify emerging needs.	Documentation of review and update of the plan as appropriate and signed and dated.
Assist HAHSTA/ADAP with the purchase process of 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. *Note:* Purchased health coverage includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents and provides comprehensive primary medical care.	Documentation of health insurance premiums that provide OAHS and pharmacy benefits.
Methodology in place to demonstrate purchase of health insurance is cost effective in the aggregate in comparison to the full cost of medications and other appropriate HIV outpatient ambulatory health services.	Summary of comparative costs.
Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of eligible clients.	Documentation of co-pays and deductibles in client's record.

Note: If funds are used to cover co-pays for prescription eyewear, a physician's written statement confirming the eye condition is related to HIV infection is required.	Documentation of Physician's written order/prescriptions for eye glass in clients record.
All health insurance premium and cost-sharing assistance services provided is documented in client record.	Documentation of health insurance premium and cost-sharing assistance is in client's record signed and dated.
Providing funds to contribute to an eligible client's Medicare Part D true out-of-pocked (TrOOP) cost.	Clients maintain their Medicare Part D coverage and advance through the self-pay/donut hole tier of Part D into the Catastrophic Tier (final tier)
TRANSITION & DISCHARGE	
Standard	**Measure**
Customer discharged when HIPCS services are no longer needed, goals have been met, upon death or due to safety issues. <u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not present to sign for the letter, it must be returned to the provider. <u>Transfer</u>: If customer transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location. <u>Unable to Locate</u>: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. <u>Documentation</u>: Customer's record must include: ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge ● Reason(s) for discharge ● Referrals made at time of discharge, if applicable

from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.	
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals ● Decides to transfer to another agency ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● 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	Documentation of case closure in customer's record with clear rationale for closure

despite three documented attempts to contact customer ● 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	

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

The agency shall ensure:

- that its insurance assistance staff who provide direct services to clients shall have had at least two years of college, and shall have had a minimum of six months experience providing services in this, or a related field. A total of three years of relevant experience in this or a related field can substitute for the education requirement;
- that its insurance assistance staff who provide direct services to clients have continuing access to the most up-to-date information available about effective medical care of those with HIV/AIDS, and about applicable insurance programs and options;
- a working knowledge of the COBRA and OBRA insurance programs, and various private insurance programs, including eligibility requirements, benefits, applicable deductibles and co-pays; and
- the skills and experience necessary to work effectively with HIV/AIDS service providers in a variety of disciplines and at all levels, and with a variety of clients.
- Ongoing orientation and information about advances in medical care and treatment of those with HIV/AIDS, and about changing insurance programs and options.

IX. CLINICAL QUALITY MANAGEMENT

Include at least one performance measure in the clinical quality program for the service. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

X. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on January 2, 2024. The next annual review is July 31, 2025.

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