Las Vegas Transitional Grant Area
Planning Council

Health Insurance Continuation and Cost Sharing Assistance Standards of Care

Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Health insurance premium & 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, risk pools, co-payments, and deductibles.

Funds awarded under Parts A, B and C of the Ryan White HIV/AIDS Program may be used to support a Health Insurance Premium and Cost-Sharing Assistance Program, a core medical service, for eligible low-income HIV-positive clients.

- Under this service category, funds may be used as the payer-of-last-resort to cover the cost of public or private health insurance premiums, as well as the insurance deductible and co-payments.
- The exception is that Ryan White HIV/AIDS Program funds may NOT be used to cover a client's Medicare Part D "true out-of-pocket" (i.e. TrOOP or donut hole)" costs.
- Consistent with the Ryan White HIV/AIDS Program, "low income" is to be defined by the EMA/TGA, State or Part C Grantee.

Important: Grantees should refer to the HAB Policy Notice-07-05, "The Use of Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance"
http://hab.hrsa.gov/law.htm

1.2 Key Definitions

The Las Vegas Transitional Grant Area (TGA) has designated the following definitions in an effort to standardize language across all programs for both the community being served and the

staff providing these services.

As used herein, the term:

Grantee: Ryan White Part A Las Vegas TGA-Clark County Social Services.

Client: includes the terms "patient" and "consumer".

Provider: includes the terms "service provider"; "agency"; "organization" and "subgrantee".

2. Service Goal

2.1 Las Vegas Transitional Grant Area (TGA) Health Insurance Continuation and Cost Sharing Assistance Service Goal:

To ensure access to medical care and cost effective utilization of Ryan White funds.

3. Key Services

- Provide assistance for health/dental/vision insurance premium payments, co-payments, and deductibles to clients not eligible for coverage by ADAP.

4. Eligibility

4.1 Part A

The following eligibility criteria is to be used for determining if a client is eligible for Part A services. This documentation must be verified during each eligibility assessment and re-assessment period. Every potential Part A client must have an initial eligibility assessment to ensure that they are eligible to receive a Part A service and will undergo an eligibility re-assessment every six months to ensure that the client's status has not changed. All Part A clients must meet the following criteria regardless of their service needs to be eligible for Part A services.

1. Proof of HIV Infection
2. Proof of Nevada or Arizona Residency
3. Proof of Identification
4. Proof of Household
5. Proof of Income Level
6. Asset Test (Regarding Income Determination)
7. Miscellaneous Provisions

4.2 Health Insurance Continuation and Cost Sharing Assistance

The following eligibility is for any client determined eligible for Part A services but must also meet the criteria specific for this service category.

Clients are to be referred to Health Insurance Continuation and Cost Sharing Assistance program from another Ryan White funded program after Part A eligibility is determined and only when other options are not available such as denial or non-eligibility by the State ADAP program making this program the payor of last resort.

5. Clients Rights and Confidentiality

All providers' staff should be able to document the following in terms of clients' rights and confidentiality for each Part A funded client that are receiving services. In addition, this documentation shall be available for program monitoring compliance by the grantee designated staff:

1. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.

2. The provider will provide assurances and a method for protection of client rights in the process of care provision.

3. The provider will provide assurances and a method for protection of client confidentiality (in accordance with Nevada State law as well as with HIPAA) with regard to medical information transmission, maintenance and security.

4. The provider will provide assurances regarding the provision of culturally appropriate care to its clients. Specifically, the providers' staff must have appropriate training, supervision and/or experience with caring for those groups most affected by the epidemic. This training may be provided within the providers' organization as well as any other grantee recommended trainings.

5. Respect, confidentiality and equal access to all clients will be assured.

6. Grievance Procedures-Part A

All providers will ensure that:

1. Each client will receive a copy of a Ryan White Part A grievance procedure upon eligibility and acceptance as a Part A client. The grievance procedure will clearly indicate the process of a grievance regarding Ryan White Part A service(s) only with final appeal directly to the Part A grantee office.

2. Grievance procedures will be signed by each client with a signed copy included in the clients Part A files.

3. The grievance procedure will be reviewed with each client no less than one time annually and no more than two times per year.

7. Client Satisfaction

Client satisfaction surveys as well as other provider methods will be monitored at minimum on an annual basis for each provider site. The program indicator is as follows:

- 75% of clients will report being satisfied or very satisfied with the Ryan White Part A services they have received for their HIV status over the past 12 months.

8. Access, Care Coordination and Provider Continuity

- All providers, regardless of type of service that they are funded to provide (core or support) will ensure that (medical) case coordination and collaboration between providers will occur in order to ensure that all of the client's needs are being met, identify any potential for needs to go unmet and measure the progress of the clients care.
- Providers will document the following regarding access to and continuity of care:
    - Care/action plans that will include timeframes for delivery of services (this should be documented in the client's chart).
    - Procedures for making, receiving and tracking referrals to/from other providers must be developed and implemented and will include follow-up procedures.
    - Procedures for providing feedback to referring providers when a client is referred from another provider.
    - For all those providers that are providing Part A services, with the exception of outpatient ambulatory medical services, verification that a client is currently receiving primary medical care should be documented in the client's chart.

9. Fees

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee in order to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. Decrease in fees must also be reported so that expansion to serve more clients can be reviewed and implemented if applicable.

10. Licensing, Knowledge, Skills and Experience

Minimum HS Diploma; college graduate preferred. Should have HIV related experience. If qualified individuals do not have HIV related experience they must receive HIV specific training within six months of hire.

11. Quality Assurance and Service Measures

11.1 Quality Management and Assurance

1. All providers will have written quality-assurance activities and methods that can identify any areas that may require improvement and action steps required to strategically improve these areas.

2. The provider organization will provide for methods to monitor services areas in need of improvement.

3. Regular utilization review of the clinical measures and data for individual clients will be conducted to ensure client's progress is being monitored. Utilization review decisions will be clinically based on best practices and consistent with emerging national standards.

11.2 *Service Indicators and Measures*

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. All measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client Level Outcome Measures, and Overall Program Performance Measures. The intent is that agency compliance with standards of care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at each agency receiving Part A funding and client satisfaction surveys. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

Agency Compliance Measures for Health Insurance Premium and Cost Sharing Assistance services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

12. Clinical Standards

The Client Level Outcome Measures are a reflection of our client's progress as they access Health Insurance Continuation and Cost Sharing Assistance services. The following Client Level Outcome Measure and percentage goal will be assessed annually:

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4 T-cell Count

- 75% of clients will stabilize or increase their CD4 T-cell count from initial count within the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200)

Undetectable Viral Load

- 75% of clients that maintained an undetectable viral load or achieved an undetectable viral load from initial count within the measurement period.

Most Recent Viral Load Undetectable

- 75% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

13. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Health Insurance Continuation and Cost Sharing Assistance services. It is expected that all providers follow these standards as well as the universal programmatic and administrative standards of care. Provider organizations and staff may exceed any of these standards as part of the program delivery.

14. Recommendations

All Part A funded providers are to adhere to these service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual Part A contracts to meet the expectations of their deliverables.

15. References and further reading

All Part A funded providers should read their individual Part A contracts as well as but not limited to the Quality Management Plan and all local policies and guidelines set forth by the Part A office regarding the Part A program in the Las Vegas Transitional Grant Area. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

16. Appendices

Not Applicable.