HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS STANDARDS OF CARE

FOR

HIV SERVICES IN ORANGE COUNTY

Reviewed by Planning Council 04/09/25

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SECTION 1: INTRODUCTION

The goal of health insurance premium and cost sharing for low-income individuals (HIP) is to assist persons living with HIV (PLWH) in Orange County with staying in care.

Goals of the Standards

These standards of care are provided to ensure that Orange County's HIP services:

- Are accessible to all PLWH who reside in Orange County
- Promote continuity of care
- Enhance coordination among service providers to eliminate duplication of services
- Maintain the highest standards of care
- Protect the rights of PLWH
- Enable clients to stay in medical care and reduce barriers to services
- Increase client self-sufficiency and quality of life

SECTION 2: DEFINITION OF HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS

Health Insurance Premium and Cost Sharing Assistance 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. 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

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- Paying cost sharing on behalf of the client (e.g., co-insurance, medical co-payment, mental health co-payment, medication co-payment, eyewear/vision co-payment.

SECTION 3: STAFFING REQUIREMENTS AND QUALIFICATIONS

Quality services start with well-prepared and qualified staff. To ensure this, Ryan White providers must meet all of the following requirements and qualifications:

- **HIV Knowledge.** Staff shall have training and experience with general HIV-related related issues and concerns. At a minimum, staff will have completed an initial and annual educational session in one (1) of the topics listed below. Education can include round table discussion, training, one-on-one educational session, in-service, or literature review.
    - HIV disease process and current medical treatments
    - Privacy requirements and Health Insurance Portability and Accountability Act (HIPAA) regulations
    - Cultural issues related to communities affected by HIV
    - Human sexuality, gender, and sexual orientation affirming care
    - Transmission of HIV and other communicable diseases

- **Legal and Ethical Obligations.** Staff must be aware and able to practice under the legal and ethical obligations set forth by California state law and their respective professional organizations. Obligations include the following:
    - **Confidentiality:** Maintenance of confidentiality is a primary legal and ethical responsibility of the service providers. Limits to maintaining confidentiality include danger to self or others, grave disability, child/elder/dependent adult abuse. Domestic violence must be reported according to California mandated reportinglaws.
    - **Duty to warn:** Serious threats of violence (including physical violence,serious bodily harm, death, and terrorist threats) against a reasonably identifiable victim must be reported to authorities. However, at present, in California, a PLWH engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality. Staff should follow their agency's policies and procedures in relation to duty to warn.

- **Culturally Appropriate.** Staff shall possess the ability to provide services to accommodate clients with disabilities, including communication barriers (services for clients who may have concerns such as hard of hearing, low literacy skills, and/or visually impaired) and culturally appropriate services for PLWH.

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Standard	Measure
Staff agree to maintain standards set forth in Code of Conduct	Documentation of staff signature on file
Staff will have a clear understanding of job responsibilities	Written job description on file signed by staff and supervisor
All staff (including administrative staff) will receive initial education trainings within 60 days of hire and annual trainings regarding HIV related issues/concerns	Documentation of training/education on file

SECTION 4: CULTURAL AND LINGUISTIC COMPETENCE

Providers must participate in a process of training and education that increases cultural and linguistic competence and improves their ability to provide culturally and linguistically appropriate services to all PLWH. Although an individual's ethnicity is generally central to their identity, it is not the only factor that makes up a person's culture. Other relevant factors include gender, language, religious beliefs, disability, sexual orientation, beliefs, and institutions. When providing culturally and linguistically competent services, it is important to acknowledge one's personal limits and treat one's client as the expert on their culture.
Based on the Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards), culturally and linguistically appropriate services and skills include:

- Effective, equitable, understandable, and respectful services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- The ability to respect, relate, and respond to a client's culture in a non-judgmental, respectful manner.
- Meeting the needs and providing services unique to our clients in line with the culture and language of the clients being served, including providing written materials in a language accessible to all clients.
- Recognizing the significant power differential between provider and client and work toward developing a collaborative relationship.
- Considering each client as an individual, not making assumptions based on perceived memberships in any specific group or class.
- Translation and/or interpretation services to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all services.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Being non-judgmental in regards to people's sexual practices.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Standard	Measure
Service providers shall recruit a diverse staff that reflects the culture (including gender, sexual identity, and disability) of the community served	Service providers shall have a written strategy on file
All staff (including administrative staff) shall receive initial within 60 days of hire and annual training to build cultural and linguistic awareness	Documentation of training/education on file
Service provider shall have posted and written materials in appropriate languages for the clients served	Site visit will ensure
Service provider will maintain a physical environment that is welcoming to the populations served	Site visit will ensure
Service provider complies with American Disabilities Act (ADA) criteria	Completed form/certification on file
Services are accessible to community served	Site visit to review hours of operation, location, accessibility with public transportation
Service provider will maintain a physical environment that is welcoming to the populations served	Site visit will ensure

SECTION 5: CLIENT REGISTRATION

Client registration is required for all clients who request or are referred to Ryan White health insurance premium and cost sharing assistance services. Registration is a time to gather registration information and provide basic information about service availability. It is also a pivotal moment for establishment of trust and confidence in the care system. Staff shall be careful to provide an appropriate level of information that is helpful and responsive to client need.

If a client is receiving multiple Ryan White services with the same provider, registration only needs to be conducted one time. It is acceptable to note that eligibility, registration, and required documents discussed in this section were verified and exist in another client record at the same provider agency.

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Provision of information regarding *Client Rights and Responsibilities*, *Client Grievance Process, and Notice of Privacy Practices (NPP)* may be conducted one-time at the referring provider agency. To document the provision of this information, the referring provider may send the

health insurance premium and cost sharing assistance provider a signed document indicating that they have provided this information to the client.

The following describe components of registration:

- Staff shall respond to phone calls within two (2) business days upon receipt of phone call from a client and/or case manager.
- Staff shall schedule an initial appointment within five (5) business days of client contact.
- Registration shall take place as soon as possible. If there is an indication that the client may be facing a medical crisis, the registration process shall be expedited and appropriate intervention may take place prior to formal registration.
- The service provider shall obtain the appropriate and necessary demographic information to complete registration as required for the Ryan White Services Report (RSR). This may include, but is not limited to, information regarding demographics, risk factors, HIV medical history, living situation, employment and financial status, service linkages, and emergency contact information.
- Staff shall clearly explain what services entail the availability of various services.
- Staff shall communicate information to clients described below:
    - Written information about resources, care, and treatment (this may include the county-wide HIV Client Handbook) available in Orange County.
    - Information about filing a **Grievance** if the client feels their rights have been violated.
    - A copy of the client's **Rights and Responsibilities** (included in the HIV Handbook or Provider's Rights and Responsibilities).
    - Clients shall also be given the **NPP** form. Clients shall be informed of their right to confidentiality. It is important not to assume that the client's family or partner knows the HIV-positive status of the client. Part of the discussion about client confidentiality shall include inquiry about how the client wants to be contacted (at home, at work, by mail, by phone, etc.).
- The provider shall also obtain the following required documents:
    - A **Consent for Services** form, signed by the client, agreeing to receive services.
    - Clients shall be informed of HIV Care Connect (HCC) and obtain an **HCC consent**. The HCC consent must be signed at intake prior to entry into the HCC database and every three (3) years thereafter. The signed consent form shall authorize the Office of AIDS (OA) to record and track their demographic, eligibility, and service information and share this information with other agencies in the Ryan White system of care.
    - A signed document indicating receipt of **Rights and Responsibilities**. Client rights and responsibilities incorporate a client's input; and provide a fair process for review if a client believes they has been mistreated, poorly served, or wrongly discharged from services.
    - If there is a need to disclose information about a client to a third party, including family members, client shall be asked to sign an **Authorization to Disclose (ATD)/Release of Information (ROI)** form, authorizing such disclosure.

This form may be signed at registration prior to the actual need for disclosure. Releases of information may be cancelled or modified by the client at any time.

Standard	Measure
Client shall be contacted within two (2) business days of client contact	Registration tool is completed and in client record
HCC Consent signed and completed prior to entry into HCC	Signed and dated annually by client and in client record
Client is informed of Notice of Privacy Practices	Signed and dated by client and in client record
Client is informed of Rights and Responsibilities	Signed and dated by client and in client record
Client is informed of Grievance Procedures	Signed and dated by client and in client record
Consent for Services	Signed and dated by client and in client record
Authorization to Disclose (ATD)/Release of Information (ROI) is discussed and completed as needed	Signed and dated by client and in client record

SECTION 6: HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE SCREENING

Service provider shall conduct a screening and assessment of the client's needs and eligibility/qualifications for services.

- **Screening:** To quality for health insurance premium and cost sharing assistance services, the client must meet eligibility screening **AND** payer of last resort criteria (assess lack of other resources for health insurance premium programs) and be re-screened for eligibility/qualification annually or when a change has occurred that impacts a client's eligibility/qualification for services.
- **Assessment:** The client must be assessed for the need for assistance with health insurance premium payments and/or cost sharing.

Standard	Measure
Eligibility screening including assessing payer of last resort conducted every six (6) months or when a change has occurred that impacts a client's eligibility/qualification for services.	• Documentation in client record • Site visit will ensure
Assessing need for services	• Documentation in client record • Site visit will ensure

SECTION 7: SERVICE MANAGEMENT

Once client registration and screening have been conducted, the provider may provide health insurance premium and cost sharing assistance services to the client. Service management shall be consistent with the following principles:

- **Service Delivery**
  - Health care coverage at a minimum includes at least one (1) U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services
  - If funds are to be used for standalone dental insurance premium assistance, service providers must have a process to ensure that the aggregate cost of paying for the standalone dental insurance is more cost effective than paying for the full cost of HIV oral health care services
  - Service provider must have a process to ensure that the aggregate cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is more cost-effective than paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services.
  - Policies available under ACA (Covered CA) meet requirements set by HRSA including comprehensive medical and pharmacy benefits.
  - Service record shall include type, date, and method of assistance
- **Confidentiality**
  - Service provider agencies shall have a policy regarding informing clients of privacy rights, including use of Notice of Privacy Practices. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), providers shall comply with HIPAA guidelines and regulations for confidentiality.
- **Service Planning**
  - Where service provision options are substantially equivalent, the least costly alternative shall be used in meeting the needs of clients.
  - Services shall be planned, managed, and monitored to avoid the need for urgent or emergency services.
- **Documentation and Data Collection**
  - Program and administrative staff shall provide adequate data collection in a timely manner and documentation of all services provided for accounting, reporting compliance, and evaluation purposes.
  - Program data shall be entered into HCC within five (5) business days as specified in contract or scope of work.
  - Service providers shall document and keep accurate records of units of services for use in reporting units of service for reimbursement and community planning.
  - Service providers shall gather and document data (e.g., demographic, eligibility, and risk factor information) for the RSR.

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- Service providers shall document duration of assistance
  - Service providers shall document payment made directly to health insurance company, healthcare provider, dental insurance company, dental provider, mental health provider, vision provider, and/or pharmacy.
  - Service providers shall provide proof that insurance policy provides comprehensive primary care and formulary with a full range of HIV medications to client
  - Service providers shall provide proof that funds were not used to cover costs of liability risk pools or social security
  - Documentation of coordination with Centers for Medicare and Medicaid Services to ensure that funds are appropriately included in TrOOP or donut hole costs
  - If funds are used to cover copays for prescription eyewear, service providers shall have documentation of a physician's written statement that the eye condition is related to HIV infection
- **Compliance with Standards and Laws**
  - Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality. Health insurance premium and cost sharing assistance shall be consistent with standards set forth in this document.

Standard	Measure
Service provider shall have procedure to address walk-ins, telephone triage, emergencies, and after-hour care	Written procedure in place
Service provider shall have procedure for making referrals to offsite services	Written procedure in place
Service provider shall have policy regarding informing clients of privacy rights, including use of Notice of Privacy Practices; for covered agencies and information, policy shall be consistent with HIPAA regulations	Written policy on file
Staff shall be aware of provider confidentiality policy via training upon employment and annually thereafter	Documentation of education or training on file
Service provider shall ensure client information is in a secured location	Site visit will ensure
Service provider shall screen clients to ensure the least costly service is used as appropriate to client needs	• Written procedure in place • Site visit will ensure
Service provider shall regularly review client records to ensure proper documentation	Written procedure in place

Standard	Measure
Service providers shall document and keep accurate records of units of services	Site visit will ensure
Required client data and services shall be entered in HCC	Required data fields will be validated by the RSR
Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality	Site visit will ensure
Service provider shall ensure that health care coverage includes, at a minimum, at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services	Site visit will ensure
If funds are to be used for standalone dental insurance premium assistance, service providers must ensure that the aggregate cost of paying for the standalone dental insurance is more cost effective than paying for the full cost of HIV oral health care services	Site Visit will ensure
Service provider shall ensure that the aggregate cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is more cost-effective than paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services	Site visit will ensure
Service provider shall ensure that policies available under ACA (Covered CA) meet requirements set by HRSA including comprehensive medical and pharmacy benefits	Site visit will ensure
Service record shall include type, date, and method of assistance	Site visit will ensure
Service providers shall document duration of assistance	Site visit will ensure

Standard	Measure
Service providers shall document payment made to health insurance company, healthcare provider, dental insurance company, dental provider, mental health provider, vision provider, and/or pharmacy	Site visit will ensure
Service providers shall provide proof that insurance policy provides comprehensive primary care and formulary with a full range of HIV medications to client	Site visit will ensure
Service providers shall provide proof that funds were not used to cover costs of liability risk pools or social security	Site visit will ensure
Service providers shall provide documentation of coordination with Centers for Medicare and Medicaid Services to ensure that funds are appropriately included in TrOOP or donut hole costs	Site visit will ensure
Service providers shall have documentation of a physician's written statement that the eye condition is related to HIV infection if funds are used to cover copays for prescription eyewear	Site visit will ensure

SECTION 8: SERVICE CLOSURE

Services provided under Health Insurance Premium and Cost Sharing Assistance are based on the need of the clients and their attempt to access services. As such, discharge or termination of services may differ from other services.

A client may be suspended or terminated from services due to the following conditions:

- The client has become ineligible for services (e.g., due to relocation outside Orange County or other eligibility requirements).
- The client no longer contacts the provider for services.
- The client's needs would be better served by another agency.
- The client demonstrates unacceptable behavior that violates client rights and responsibilities.
- The client has died.

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- **Closure Due to Client Showing No Demonstrated Need.** Providers shall periodically review client records to identify client records that should be closed based on the client's assessed needs and previous patterns of use. Additionally, if the client has missed appointments, or fails to maintain contact, and is at risk of suspension or

termination of services, the provider shall provide follow-up including telephone calls, written correspondence and/or direct contact, to strive to maintain a client's participation in care. Lastly, a client may be discharged if his/her needs would be better served by another agency and is transferred to that agency. If the client is transferring to another health provider, case closure shall be preceded by a transition plan. To ensure a smooth transition, relevant registration documents may be forwarded to the new service provider. Providers from the two agencies shall work together to provide a smooth transition for the client and ensure that all critical services are maintained.

- **Closure Due to Unacceptable Behavior.** If closure is due to unacceptable behavior that violates client rights and responsibilities, the provider shall notify the client that their services are being terminated and the reason for termination. Within the limits of client's authorization to receive mail, notification of closure shall be mailed to the client. A copy of the notification shall be documented. If the client has no known address or the provider is not authorized to send mail to the client, the provider shall document other types of notification of closure (e.g. phone calls, visit) or attempts to notify the client of closure. If the client does not agree with the reason for closure, they shall be informed of the provider's grievance procedure. Lastly, the health insurance premium and cost sharing assistance provider will inform the referring agency of the client's closure in accordance with their organization's policies and procedures.

- **Documented Discharge Summary.** A discharge summary shall be documented in the client's record. The discharge summary shall include the following items listed below in the Measure box.

- **Data Collection Closeout.** The service provider shall close out the Benefits Counseling client in the data collection system (HCC) as soon as possible, but no later than thirty (30) days of service closure. For clients receiving services other than health insurance premium and cost sharing assistance services at the same provider agency, the provider shall coordinate efforts between services to ensure that data collection closeout occurs no later than thirty (30) days of closure from all Ryan White services at that provider agency.

Standard	Measure
Client closure due to client showing no demonstrated need	Documentation of no demonstrated need in closure in client record
Notify client regarding closure if due to pervasive unacceptable behavior violating client rights and responsibilities	Copy of notification in client record For clients with no known address or who are unable to receive mail, documentation of other types of notification or attempt at notification in client record

Standard	Measure
A service closure summary shall be completed for each client who has terminated services	Client service closure summary to include: • Circumstances and reasons for discharge • Date and staff signature and/or initials
Closeout of data collection shall be completed for each client who has been closed from all Ryan White services at that provider agency	Data collection system (HCC) will indicate client's closure no later than thirty (30) days of service closure

SECTION 9: QUALITY MANAGEMENT

Providers shall have at least one (1) member on the Ryan White Quality Management (QM) Committee. The QM Committee oversees quality management activities for all providers under Ryan White Part A. Providers may continue to have their own QM committee if they desire and/or are required to do so under other funding streams. The intent of a centralized QM committee with representation from all providers is to ensure information between agencies is consistent, quality initiatives are undertaken by the entire Ryan White system, and service delivery issues can be addressed system wide.

As providers participate in the centralized QM committee, the intent is for all providers to actively participate in and provide feedback on the following items:

- Providers shall participate in community-wide Quality Improvement initiatives as developed by the QM committee.
- Providers will implement strategies that may lead to improvements in health outcomes as outlined in annual Outcome Measures.
- Providers will implement quality assurance strategies that improve the delivery of services.

Standard	Measure
Providers shall participate in annual quality initiatives	Documentation of efforts to participate in quality initiatives

Appendix A. Glossary of Terms

The terms defined in the appendix are general terms used throughout all of the standards of care and may not appear in each individual standard.

Americans with Disabilities Act of 1990 (ADA): The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as the general public.

Authorization to Disclose (ATD): Signed consent by client that wants to grant another individual or organization access to their protected health information (PHI).

Case Manager or Jail Case Manager: The assigned staff member responsible for providing services to individuals that are incarcerated or within 180 days of release. The staff member is responsible for adhering to the Ryan White Jail Case Management Standards of Care.

Client: Is a person receiving services from an Orange County Ryan White funded program who has been incarcerated or has been recently released from incarceration.

Eligibility for a service: Is based on Health Resources Services Administration (HRSA) requirements, including proof of HIV status, proof of Orange County residency, and proof of payer of last resort. Eligibility workers are responsible for verifying this information.

Eligibility Verification Form (EVF): Form used to document a client's eligibility for Ryan White services. Information includes but is not limited to contact, income, household, and insurance information.

Grant Recipient: Government recipient of Ryan White Part A funds. In Orange County, the Orange County Health Care Agency acts as the Grant Recipient for Ryan White Part A funds.

HCC: HIV Care Connect (HCC) is a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment and support providers and provides comprehensive data for program reporting and monitoring. HCC is used by Ryan White-funded service providers to automate, plan, manage, and report on client data.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Is the US federal legislation that provides data privacy and security provisions for safeguarding medical information. More information can be found through US Department of Health & Human Services at https://www.hhs.gov/hipaa/for-professionals/index.html.

HIV Planning Council (Council): Provides advice and makes recommendations to the County regarding HIV policy issues, service needs of the community, and allocates funds to each service funded under the Ryan White Act and advises the County on Housing Opportunities for People with AIDS (HOPWA) funds.

Notice of Privacy Practice (NPP): A notice to clients that provides a clear, user friendly explanation of client's rights with respect to their personal health information and the privacy practices of health plans and health care providers as required by HIPAA.
Payer of last resort: Funds are used to pay for care services that are not covered by other resources such as Medi-Cal or private health insurance.

Protected Health Information (PHI): Under US law, any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity such as a health plans, health care clearinghouses, and health care providers as defined by HIPAA rules that can be linked to a specific individual.

Provider: An institution or entity that receives funding to provide Ryan White services. This includes a group of practitioners, clinic, or other institution that provide Ryan White services and the agency at which services are provided.

Qualifying for a Service: Based on HRSA eligibility and Planning Council determined requirements (for example, proof of disability for Food Bank, income less than 300% of Federal Poverty Level for Mental Health Services), providers are responsible for ensuring that services provided adhere to qualifying requirements.

Release of Information (ROI): Signed consent by client that wants to grant another individual or organization access to their protected health information (PHI).

Ryan White Act: Federal legislation first authorized in 1990 that created Ryan White HIV/AIDS Program which provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured.

Staff: An individual who directly provides Ryan White services, oversees the provision of Ryan White services, or perform administrative functions for Ryan White services. This may include paid employees, subcontractors, volunteers, or interns