BROWARD COUNTY HUMAN SERVICES DEPARTMENT

RYAN WHITE PART A PROGRAM

Health Insurance Continuation Program

Service Delivery Model

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Service Delivery Model

The Service Delivery Model serves as a minimum set of standards to be followed by all providers of Health Insurance Continuation Program services funded by the Broward County Human Services Department through its Community Partnerships Ryan White Part A Program.

For purposes of this Service Delivery Model ("SDM"), the term "provider" means any entity or group that has an agreement with Broward County Human Services. The term "Client" describes an individual who is eligible for County-funded services. As capitalized, the "Agreement" refers to the executed contract between the County and the provider.

I. PROGRAM DEFINITION

The Health Resources and Services Administration's (HRSA) Health Insurance Premium and Cost Sharing Assistance Program 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 for this service category[1]. 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.

In Broward County, the Health Insurance Premium and Cost Sharing Assistance Program is referred to as the Health Insurance Continuation Program (HICP). This includes the provision of financial assistance paid on behalf of eligible Clients living with HIV to maintain continuity of health insurance or to facilitate receiving medical and pharmacy benefits under a Ryan White AIDS Drug Assistance Program (ADAP)-approved Affordable Care Act (ACA) health care coverage program.

The goal of this program is to maintain a client's private health insurance coverage, thus minimizing the Client's reliance on the Ryan White Part A program for services. No payments or reimbursements can be made directly to a client.

HICP is available to assist low-income, program-eligible Clients. HICP assistance is limited

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

to out-of-pocket HIV/AIDS-related healthcare coverage costs, including:

- Medical deductibles,
- Copayments,
- Coinsurance (for medications that are not on the Ryan White ADAP Formulary)

These Clients must be enrolled in an ADAP Premium Assistance program and an ADAP-approved ACA health insurance plan. The Ryan White Part A program does not assist with ACA premium payments, as the Florida ADAP pays these premiums. The coverage of HICP is also **limited** to the annual out-of-pocket max per Client, as detailed in the taxonomy table. A complete financial assessment and disclosure from the Client is required in all cases. The HICP service provider must have policies and procedures to inform and assist Clients in navigating the service category.

The HICP service provider will coordinate with third-party providers to assist with Client access to services and maintain a list of providers for medical and pharmaceutical services that accept HICP payments. At a minimum, this provider list must be updated each time a new provider agrees to be added to the list, and it may be shared with Clients upon request. The HICP service provider must also communicate, at minimum upon Client request, with third-party providers to inform them of the details of HICP reimbursement and assist in gaining provider acceptance of HICP third-party reimbursement.

- ***Third-Party Benefits:*** *An example of third-party benefits include, but is not limited to Medicaid, Medicare, Private Health Insurance plans, Supplemental Nutrition Assistance Program (SNAP), Employer-sponsored Health plans, Affordable Care Act (ACA) Marketplace Health Insurance plans, etc.*
- ***Aids Drugs Assistance Program:*** *The AIDS Drug Assistance Program (ADAP) is a statewide, federally funded prescription medication program for low-income people living with HIV. This program provides access to medications to eligible clients either directly or by purchase of health insurance that includes coverage for HIV medications.*
- ***Affordable Care Act:*** *The Affordable Care Act (ACA) is a comprehensive reform law, enacted in 2010, that increases health insurance coverage for the uninsured and implements reforms to the health insurance market. Under the Affordable Care Act, patients who may have been uninsured due to preexisting conditions or limited finances can secure affordable health plans through the health insurance marketplace in their state.*

II. KEY SERVICE COMPONENTS AND ACTIVITIES

Broward County, HSD-funded HICP service providers are required to adhere to the HICP Service Delivery Model (SDM). Additionally, all providers must adhere to the minimum requirements outlined in the Broward County Ryan White Part A Universl SDM, the Title XXXVI - HIV Health Care Services. Providers are expected to comply with rules set forth by the applicable State, Federal and local standards and guidelines relevant to services

delivered within this service category. Providers must also adhere to standards and requirements outlined in the Broward County Human Services Department Provider Handbook for Contracted Service Providers, and applicable contract adjustments for service-specific Client eligibility requirements.

As a service category, HICP can assist with HIV-related medication copayments and deductibles, as well as HIV-related doctor visits, lab visits, and outpatient procedure visits. This assistance is limited, not guaranteed and is dependent on funding availability.

Prior to receiving health insurance assistance, Clients must review, understand, and accept in writing all HICP policies and procedures approved by the Broward County Ryan White Part A Recipient Office and the HICP service provider. Documentation of acceptance of these policies must be signed and dated by the Client.

Table 1: HICP Requirements for Medications and Medical Services

Medical Services	Medications
Medical service(s) must be covered by a Client's ADAP-approved health insurance plan.	Medications must be covered by a Client's ADAP-approved health insurance plan.
Medical service(s) must be provided by an **in-network** provider on the Client's insurance plan. Out-of-network provider visits, labs, and other services are not covered.	Medications **cannot** be listed on the Florida ADAP Formulary.
Payments cannot be made for services provided in the emergency department, for hospital-based inpatient service, or for conditions that are not related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment.	Payments cannot be made for medications to treat conditions that are not related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment.

Population of Focus/ Eligibility Criteria

The population of focus for this service category are individuals who are Broward County residents with HIV/AIDS who earn less than or equal to 400% of the Federal Poverty Guidelines, are uninsured or under-insured, have barriers to economic stability and have no other means or funding source to receive services. For a full description of the population of focus, the details will be in the Broward County's Ryan White Part A Universal SDM.

Documentation of Eligibility

The provider must verify Client's financial and program eligibility for treatment prior to Client receiving services. Verification of Client eligibility is accomplished by examining supporting documentation.

The Client completes a benefits assessment with Centralized Intake and Eligibility Determination (CIED) to determine Ryan White Part A services and other third-party benefits. The benefits assessment is documented in the designated HIV Human Services Software System (HIV HSSS) and the Client receives a notice of eligibility determining if they are eligible for HICP services. The provider must include all supporting documentation in the Client's record in the designated HIV HSSS and note the outcome of the eligibility verification.

Client Orientation

The HICP service provider must ensure that new and returning Clients are familiarized with the HICP process. The HICP service provider must review all orientation materials, policies and procedures, and Client acknowledgment forms with the Client that the Broward County Recipient Office approves. Documentation of acceptance of the Client acknowledgment form must be signed and dated by the Client at the end of the orientation. Clients must be informed that the Ryan White Part A program cannot assist with paying any fees/penalties from prior years associated with the Client not having an ADAP-approved health insurance plan. Clients must also be notified that a service provider does not have to accept third-party payments. Ultimately, it is up to the service provider to agree to third-party payments.

Clients must be informed that it is their responsibility to share information regarding HICP reimbursement with their service provider at least four (4) weeks before their next scheduled appointment date to gain provider buy-in and encourage the service provider to coordinate payment assistance setup with the HICP service provider. The HICP service provider must make clear to the Client that HICP cannot reimburse the Client for copays, deductibles, or another coinsurance that the Client pays out-of-pocket to a provider.

If the facility chooses not to accept, the Client can either:

- Choose another service provider that accepts HICP payment assistance or
- Proceed with the appointment, which will make the Client responsible for making the payment themselves. HICP cannot reimburse payments made by the Client.

Payment Verification

The HICP service provider must, upon request by a Client or service provider, inform healthcare providers about the HICP process, including billing setup, steps, covered services, and expected timelines. The HICP service provider must have a system in place to ensure funds pay only for eligible pharmaceuticals and in-network outpatient services. The HICP service provider must ensure that all funds are being used as a last resort when Clients utilize their existing ADAP-approved ACA insurance plan.

The HICP service provider must examine documentation to ensure copayments, coinsurance, and deductibles are valid based on eligible insurance plan benefits, insurer, and HICP policies.

The HICP provider must encourage Clients to schedule relevant medical appointments before January since the Ryan White fiscal year ends on February 28 (29), and reimbursements cannot be made across Ryan White fiscal years. HICP Clients are responsible for submitting a request for payment to HICP within 30 calendar days of the rendered service(s) and must be encouraged to proactively follow up with their providers if

billing for services is not received on time. Payment of invoices received after 30 calendar days are dependent on HICP funding availability. The HICP service provider must notify Clients within 5 calendar days if they will not accept their payment request for any reason.

All invoices for payment may be sent via email or fax and include the following:

- Client's Legal Name
- Date of Birth
- Date of Service
- Amount and type of payment request (Copayment, Coinsurance, or Deductible)

Payment verification documentation must show that the insurance covered the service(s) and that those service(s) were HIV-related to the extent that the services were intended to treat conditions related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment. The HICP service provider must receive documentation from a medical practitioner indicating a client received an HIV-related service for eligible payments to be processed.

The HICP service provider cannot process any invoices after the closeout period at the end of the Ryan White fiscal year nor pay the service provider on the Client's behalf after the indicated deadline.

Coordination with Third Party Providers

The HICP service provider must educate Clients on services available through HICP and provide guidance on HICP processes, timelines, and limitations. The HICP service provider must strongly encourage Clients to use their insurance plan in-network providers. Failure of Clients to utilize their in-network insurance plan will result in a disallowance of cost-sharing support.

III. STANDARDS FOR SERVICE DELIVERY

Table 2. HICP Standards for Service Delivery

Standard	Measure
1. Clients acknowledge acceptance of HICP policies, procedures, timelines, and limitations during orientation to HICP.	1.1. The HICP Policies and Procedures Acknowledgment form is signed and dated by the Client and uploaded in the designated HIV HSSS.
2. Clients are instructed to offer information regarding HICP to their medical and pharmaceutical service providers no fewer than four (4) weeks before the next scheduled appointment.	2.1. The HICP Policies and Procedures Acknowledgment form is signed and dated by the Client and uploaded to the designated HIV HSSS.
3. The HICP service provider verifies that the eligible insurance plan was effective	3.1. An active insurance policy is documented in the designated HIV

Standard	Measure
on the date of service.	HSSS.
4. The HICP service provider verifies that services were provided by a service provider that is in the insurance plan's network.	4.1. Documentation of the service provider's participation in the HIV HSSS network.
5. The HICP service provider must develop a system to ensure funds pay only for in-network outpatient services.	5.1. Documentation of HICP policies and procedures in designated HIV HSSS.
6. The HICP provider must scan invoices and proof of payment.	6.1. Documentation of insurance information in the designated HIV HSSS. 6.2. Verify that the invoice and payment are correct. 6.3. Duplication of documents will not be accepted. 6.4. All invoices for payment must include the Client's legal name, Date of Birth, Date of Service, Amount, and type of payment request (Copayment, Coinsurance, or deductible)
7. The HICP service provider must process eligible health insurance invoice(s) within 15 calendar days of receiving payment requests from the Client.	7.1. Documentation of date of receipt of copay, coinsurance, and/or deductible payment request in designated HIV HSSS. 7.2. Proof of payment (invoice) is documented in the designated HIV HSSS.
8. The HICP service provider will, at the request of the Client or a medical or pharmaceutical service provider, orient/educate service providers regarding the benefits of HICP to gain the provider's acceptance of HICP third-party payments.	8.1. Documentation of orientation/education interaction enters in the designated HIV HSSS.
9. The HICP service provider will maintain a list of providers for medical and pharmaceutical services that accept HICP payments.	9.1. Documentation of the provider list is updated, at minimum, once a year and distributed to Clients with physical and/or digital copies.

IV. Outcomes and Indicators

Table 3. Outcomes, Indicators, and Measure

Outcomes	Outcome Indicators	Data Source (Where the data used to complete the quarterly report is found, verified, and kept)	Measure (Who collects data, when how; special calculation instructions, if needed)
1. Clients maintain consistent access to medical care due to prompt invoice(s) payment.	1.1. 85% of provider(s) payments are processed within 10 calendar days of receiving all required payment documents from Clients.	Documentation of Client recertification recorded in Provide Enterprise, also known as the HIV Human Services Software System (HIV HSSS) Monthly data compilation tracking sheets. Progress notes in designated HIV HSSS.	Comparison of quarterly averages. **Calculation:** The total number of invoices processed within 10 calendar days. / The total number of submitted eligible invoices within the reporting period.