San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

HEALTH INSURANCE PREMIUM AND COST-SHARING ASSISTANCE (HIPCSA)

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Overview and Purpose of Health Insurance and Cost-Sharing Assistance Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Health Insurance and Cost-Sharing Assistance Services Standards of Care is to ensure consistency among the Ryan White- funded case management services provided as part of the San Francisco EMA's continuum of care for persons living with HIV. These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Provide client-centered services that respect the client's rights, values, and preferences;
- Coordinate any and all types of services and assistance to meet the client's identified needs;
- Minimize barriers to needed medical and wraparound support services;
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach;.
- Provide continuity of care for people with HIV within a comprehensive system of services throughout the course of their infection; and
- Appropriately address issues of consent, confidentiality, and other client rights for clients enrolled in services.

Description of Health Insurance and Cost-Sharing Assistance Services

Health Insurance Premium and 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. HIPCSA funds may be used to cover the cost of private health insurance premiums, deductibles, and co-payments to assist eligible low-income clients in maintaining health insurance or receiving medical or pharmacy benefits under a health insurance or benefits program, including high risk pools. HIPCSA funds may be used to pay dental insurance premiums to ensure access to comprehensive oral health care services for eligible clients, and for paying cost

sharing on behalf of clients in forms such as medical co-payments, mental health co-payments, medication co-payments, eyewear / vision co-payments, and pharmaceutical costs not covered through Medicare Part D. However, HIPCSA funds may not be used to pay for any administrative costs outside of the direct premium payment of the health plans or risk pools.

Units of Service:

A Health Insurance Premium and Cost-Sharing Assistance Unit of Service is defined as:

- Any single, authorized, documented HIPCSA payment with a corresponding dollar amount.

Health Insurance Premium and Cost-Sharing Assistance Requirements:

Screening:

To quality for health insurance premium and cost sharing assistance services, clients must meet eligibility screening **and** payer of last resort criteria (e.g., 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. Providers must make reasonable efforts to secure non-Ryan White funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible, including Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance programs prior to qualifying clients for HIPCSA support.

Distribution and Monitoring of Funds:

- Health care coverage supported through HIPCSA must include at least one (1) U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines as 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.
- In addition to ensuring that HIPCSA payments represent the funding source of last resort, service providers must have a process to ensure that the aggregate cost of paying for the health care or behavioral 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 or behavioral 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 records maintained by HIPCSA providers shall include type, date, and method of assistance provided, along with a rationale for the use of HIPCSA funds as the most cost-effective, last-resort approach possible.
- Mechanisms must be created and maintained to ensure that HIPCSA payments are made directly to insurers and providers on behalf of clients, with no direct payments made to clients or to family or household members.