Utah Ryan White Part B Manual

Utah Department of
Health & Human Services
Population Health

Division of Population Health
Office of Communicable Diseases
HIV/STD Elimination, Analysis, Respond and Treatment

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INTRODUCTION

Ryan White HIV/AIDS Program (RWHAP)

The Ryan White HIV/AIDS Program, classified by Title XXVI of the Public Health Service (PHS) Act, and amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009) is the largest Federal program directed exclusively toward HIV/AIDS care. The Program awards funding to provide primary care and support services to people living with HIV/AIDS (PLHIV) who have no health insurance or gaps in health insurance coverage. The Ryan White HIV/AIDS Program services more than half a million people each year by awarding grants to cities, states, and local community-based organizations that provide HIV-related services. According to the Health Resources and Services Administration (HRSA):

"The principle intent of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program) is to provide services to persons infected with the Human Immunodeficiency Virus (HIV), including those whose illness has progressed to the point of clinically defined Acquired Immune Deficiency Syndrome (AIDS)."

The Ryan White HIV/AIDS Program has various parts focused on meeting specific needs communities and populations have when affected by HIV/AIDS:

- Part A provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic.
- Part B provides grants to States and Territories.
- Part C provides comprehensive primary health care in an outpatient setting for people living with HIV disease.
- Part D provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS.
- Part F provides funds for a variety of programs, including Special Projects of National Significance (SPNS), the AIDS Education and Training Centers (AETC), dental programs and the Minority AIDS Initiative program.

Currently, Utah receives Part B, Part C, Part D and Part F (AETC) funding. Please note this manual specifically addresses Part B Program policies and procedures.

For information regarding Part C, Part D and Part F, please contact The University of Utah Hospitals and Clinics.

The Ryan White HIV/AIDS Program at the federal level is administered by the U.S. Department of Health and Human Services (HHS), HRSA, HIV/AIDS Bureau (HAB). Information specific to Ryan White legislation can be accessed via http://hab.hrsa.gov/abouthab/legislation.html

Terminology

This manual contains terminology and acronyms that are specific to the Utah Ryan White Part B Program.

AIDS Drug Assistance Program (ADAP) is the Program within the Utah Ryan White Part B Program that provides two services: ADAP-Medication Assistance (ADAP-M) and ADAP-Health Insurance Assistance (ADAP-I). The "Utah ADAP" refers to both services unless otherwise specified.

ADAP-M is terminology unique to the Utah Ryan White Program and refers to Medication Assistance Services through the AIDS Drug Assistance Program (ADAP).

ADAP-I is terminology unique to the Utah Ryan White Program and refers to Health Insurance Assistance Services through the AIDS Drug Assistance Program (ADAP).

Affordable Care Act (ACA) is the legislation signed by President Obama on March 23, 2010 that put in place comprehensive health insurance reforms in the United States, most notably the establishment of the online Marketplace where Qualified Health Plans (QHPs) may be purchased.

Applicants are individuals living with or affected by HIV/AIDS who are applying to access services through the Ryan White Program and have not yet enrolled in the Program.

APTC refers to the Advanced Premium Tax Credit an individual may receive when they enroll in a QHP through the Marketplace.

ClientTrack is the data management solution used by the program to apply for and maintain client eligibility, track case management activities, and track all services rendered by the Program.

DPI refers to Direct Purchase Insurance, a private-individual qualified health insurance plan purchased directly through the insurance carrier rather than purchased through the Marketplace.

Eligible client refers to an individual living with or affected by HIV/AIDS who meets all of the eligibility criteria, including HIV status, residency, and income.

Enrolled client refers to an applicant who has applied, is eligible, and been approved to receive Program services.

FPL refers to the Federal Poverty Level which is an economic measure used to decide whether the income level of an individual or family qualifies them for certain benefits and programs.

Health Resources and Services Administration (HRSA) is the federal entity that administers Ryan White funding.

Incarceration: the involuntary confinement of an individual in connection with an alleged crime. It includes involuntary confinement, either where a sentence has been determined or where the individual is detained pending adjudication of the case, as well as community supervision, such as parole or home detention.

> Transitional basis: the time-limited provision of appropriate core medical and support services for the purpose of ensuring linkage to and continuity of care for incarcerated PLWH that will be eligible for Program services upon release, when such release is imminent. Imminent release is considered by the Program as 180 days or less.
> Short-term basis: The Program may provide core medical and support services for those incarcerated individuals for 180 days or less

Internal Sources refers to any resource the Program has access to that can help determine continued eligibility for the services requested.

Marketplace refers to the Federally Facilitated Marketplace (FFM) or the Health Insurance Marketplace accessed at www.healthcare.gov.

Med-D refers to Medicare Part D or other Medicare pharmacy coverage

Program refers to the Utah Ryan White Part B Program and all related services, including ADAP-M, ADAP-I, Core Medical, Support Services and Case Management.

Part B Providers are agencies across the state of Utah that provide direct Program services to Utahns living with HIV/AIDS. The UDOH contracts with providers to make these services available.

PLHIV refers to all people living with HIV and AIDS inclusively. If a distinction is required between HIV and AIDS, PLWH refers to individuals living with HIV who have not received an AIDS diagnosis, and PLWA refers to individuals living with an AIDS diagnosis.

QHP refers to a Qualified Health Plan that meets Minimum Essential Coverage (MEC) requirements mandated by the ACA and is available through the Marketplace or directly purchased through the insurance company.

RWHAP refers to the Ryan White HIV/AIDS Program.

Utah Department of Health and Human Services (DHHS) is the grantee in Utah that receives Ryan White Part B funding from HRSA to provide Core and Support services, including ADAP-M and ADAP-I.

UTAH RYAN WHITE PART B PROGRAM OVERVIEW

The goal of the Utah Ryan White Part B Program (Program) is to provide for the development, organization, coordination and operation of an effective and cost-efficient system for the delivery of essential services to individuals and families affected by HIV disease.

Program Organization

The Program resides within the Utah Department of Health and Human Services (DHHS), Division of Population of Health, Office of Communicable Diseases, HIV/STD Elimination, Analysis, Response Treatment (HEART) Program. The Program directly administers the Utah AIDS Drug Assistance Program (ADAP), Core Medical Services, Support Services, and Quality Management Program (QM). The Utah ADAP provides both the ADAP-Medication Assistance Service (ADAP-M) and the ADAP-Health Insurance Assistance Service (ADAP-I).

The Program is administered by a Part B Administrator and an ADAP Administrator who oversee and guide Program services. A Program manager oversees overall Program administrative functions and assists the Administrators in their role. Program policies and procedures are maintained within their service area with overall policy oversight is conducted by the Program Manager.

Part B Core and Support services are overseen by the Part B Administrator. These services include outpatient/ambulatory medical care, case management, and support services. ADAP services such as medication and premium services are overseen by the ADAP Administrator. Oversight of Program twice-annual re-certification also fall under our ADAP Administrator.

Utah Continuum of Care

The Ryan White Part B Program in coordination with the HIV/STD Prevention Program at the Utah Department of Health provides comprehensive services for PLHIV in Utah along the HIV Continuum. The Utah HIV Planning Group coordinates Utah's Integrated HIV Prevention and Care Plan.

Program Funding

- Formula Grants

These federal grants are based on the number of reported living cases of HIV/AIDS in the State or Territory in the most recent calendar year.

- ADAP Supplemental Grants

These federal funds are awarded to States demonstrating severe need of medications. Funding is available based on one of the following criteria: (1) financial requirement of less than or equal to (≤) 200 percent of the Federal Poverty Level (FPL); (2) limited formulary compositions for all core classes of antiretroviral medications; (3) waiting list; (4) capped enrollment or expenditures; and, (5) an unanticipated increase of eligible individuals with HIV/AIDS.

- Part B Supplemental Grants

These federal funds are awarded to States demonstrating the severity of the HIV/AIDS epidemic using quantifiable data on HIV epidemiology, co-morbidities, cost of care, the service needs of an emerging population, unmet need for core medical services, and unique service delivery challenges.

- Emergency Relief Awards (ERF)

These federal funds are awarded to States that have implemented cost-containment measures (i.e., cost-cutting and cost-saving) due to ADAP funding shortfalls. Despite appropriation increases, demand for ADAP services began to outstrip available resources in many States resulting in their need to establish waiting lists and/or address and/or implement cost-containment measures. Therefore, emergency relief funding (ERF) is targeting the increased urgent demand for ADAP.

- Rebates

In 1992, Congress enacted Section 340B of the Public Health Services Act. This requires pharmaceutical manufacturers to enter into an agreement, called a pharmaceutical pricing agreement (PPA), with the HHS Secretary. Under the PPA, the manufacturer agrees to provide front-end discounts on covered outpatient drugs purchased by specified providers, called “covered entities,” that serve the nation’s most vulnerable patient populations.

Disproportionate share hospitals, ADAPs, and Ryan White clinics all qualify as a 340B covered entity.

- Supplemental Discounts

ADAP Crisis Task Force Supplemental Discounts were first successfully negotiated in the winter of 2003. AIDS Directors and ADAP experts from Maryland, New Jersey, New York, California, North Carolina, Texas, Massachusetts, and Utah met with pharmaceutical manufacturers to negotiate discounts on medications below current guaranteed 340B pricing for all ADAPs. Percentage of supplemental discounts differs from manufacturer to manufacturer and in some cases even medication by medication within one manufacturer's portfolio. Negotiations continue periodically to re-negotiate ongoing pricing agreements and to negotiate discounts on new medications entering the market.

- State Funds

State funds, if any, contribute to Program costs.

Federal requirements stipulate that Ryan White HIV/AIDS Program funds may not be used to pay for services covered, or which could reasonably be expected to be covered, under any State compensation program, insurance policy, or any Federal or State health benefits program, or by an entity that provides health services on a prepaid basis. The Ryan White HIV/AIDS Program is the payer of last resort.

Prohibited Activities Using Ryan White HIV/AIDS Program Funds:

- Drug Use and Sexual Activity:
  Ryan White funds cannot be used to support programs or materials designed to promote or directly encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.
- Purchase of Vehicles without Approval:
  No use of Ryan White funds by grantees or sub-grantees for the purchase of vehicles without written approval of the HRSA Grants Management Officer (GMO).
- Broad Scope Awareness Activities:
  No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public.
- Lobbying Activities:
  Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel.
- Direct Cash Payments:
  No use of Ryan White funds to make direct payments of cash to service recipients.
- Employment and Employment Readiness Services:
  Prohibition on the use of Ryan White funds to support employment, vocational, or employment-readiness services.
- Maintenance of Privately-Owned Vehicle:
  No use of Ryan White funds for direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees.
- Additional Prohibitions:
  No use of Ryan White funds for the following activities or to purchase these items:
  - Clothing
  - Funeral, burial, cremation or related expenses
  - Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied)
  - Household appliances
  - Pet foods or other non-essential products

- Off-premise social/recreational activities or payments for a client's gym membership
- Purchase or improve land, or to purchase, construct or permanently improve (other than minor remodeling) any building or other facility
- Pre-exposure prophylaxis (PrEP)

Service Overview

Utah Ryan White Part B Program

All Clients Must Meet Minimum Eligibility Criteria: HIV+ Living in Utah Low Income	CM	SS	ADAP-M	ADAP-I						
				Group Plan	Medi-caid	EB-HIPP	Med-D	COBRA	Market-place	DPI
Eligibility FPL limit	500% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL
Services*										
Non-Medical Case Management	√	√	√	√	√	√	√	√	√	√
Medical Case Management	√	√	√	√	√	√	√	√	√	√
Oral Health		√	√	√	√**	√	√	√	√	√
Emergency Financial Assistance		√	√	√	√	√	√	√	√	√
Food Vouchers		√	√	√	√	√	√	√	√	√
Transportation		√	√	√	√	√	√	√	√	√
Prescriptions			√	√	√	√	√	√	√	√
Outpatient Ambulatory Medical Care			√	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Medical Cost Sharing Assistance				√	√	√	√	√	√	√
Insurance Premiums						√	√	√	√	√

**Clients may qualify for different services based on their unique circumstances. The Part B Program will make every effort to assist the client in qualifying for the services that provide the greatest level of care.*
***Oral health is available to Medicaid enrolled individuals who do not qualify for oral health services through Medicaid.*

Standards of Care

Service standards, or standards of care, establish minimum expectations that any provider must meet when providing a service. Service standards define the core components and activities of a service category and are used by the recipient to define expectations for service procurements. By setting the basics of what is expected for any service, service standards ensure that regardless of where a client receives a service, the client will receive the same elements of the service. The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) requires RWHAP recipients, such as the Utah Ryan White Part B Program, to "work toward the development and adoption of service standards for all RWHAP-funded services," per Policy Clarification Notice (PCN) 16-02 "Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds."

The Program has developed service standards for all services provided by the Program. Service standards are reviewed/updated annually and are posted on the Program's website at https://ptc.health.utah.gov/treatment/ryan-white.

Clinical Quality Management

Under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109-415), all Ryan White HIV/AIDS Program recipients are required to establish clinical quality management programs to:

- Assess the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections.
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

The Ryan White Part B (RWB) Clinical Quality Management Plan describes the infrastructure, priorities, performance measures, quality improvement activities, action

plan/timeline, and evaluation for the RWB Program. The program strives for a culture of continuous quality improvement by following a deliberate and defined improvement process. We evaluate the program to ensure we meet or exceed legislative requirements for quality management, core medical care, and support services.

UDOH strategic priorities of the healthiest people, Medicaid optimization and a great organization. drive the RWB commitment to improving health outcomes through quality client care and satisfaction for PLWH in Utah. We seek to protect and improve the overall health of Utah's vulnerable populations, decrease health disparities, and increase health equity. We partner with internal and external stakeholders, providers, and clients to bridges gaps and support people living with HIV to access high-quality services, medications, and provide a comprehensive, client-centered continuum of care increasing viral suppression and reducing HIV transmission.

APPLICATION PROCESS	Purpose: Provides an overview of application process for Utah Ryan White Part B Services Updated: September, 2022 Next Review: March, 2023 Owner: aallred@utah.gov

APPLICATION POLICY

Applications are accepted at any time. Applicants are encouraged to work with a case management agency to submit applications to the Program. The Program uses Client Track . If required, paper forms of the application are available upon request by emailing RWP@utah.gov or available at http://health.utah.gov/epi/treatment/.

Applicants may apply for Program services by submitting a complete application through Client Track and providing documentation, as instructed in the application and in this document, which verifies they meet the eligibility requirements.

Approved Applications

Clients who submit a complete application that is approved by the Program will be considered eligible for Part B services until information is provided that serves as proof that the client no longer meets current eligibility requirements. The month in which their eligibility start date begins is considered the first month of their eligibility period. The Program will make all efforts to verify a clients' Program eligibility yearly through available internal resources. Clients will be asked to provide any updated information that is unable to be verified by the Program. Clients are able to opt out of Program internal eligibility verification at which point the client will need to provide a comprehensive recertification on a yearly basis.

Clients will be approved for all services they qualify for but will only be enrolled in ADAP upon request. Both the applicant and case management agency will receive approval notification from the Program through Client Track.

Opt Out

Clients wishing to opt out of internal eligibility verification will provide a completed Opt Out form to the Program at an anytime. A client wishing to cancel a previously signed Opt Out form will need to provide an email to rwp@utah.gov requesting cancellation.

Denied Applications

Clients who do not meet the minimum Program eligibility criteria will be denied for all services. Eligibility criteria may vary by service type. Clients may be denied for some services and approved for others depending on what they qualify for.

In the event that eligibility determination results in denial, both the applicant and case management agency will receive denial notification from the Program.

Incomplete Applications

Eligibility determination cannot be conducted for incomplete applications. Incomplete applications will not be reviewed by the Program; the case management agency will be notified it was incomplete. Services may not be provided until the application is approved and the client is enrolled.

Signature for a Minor Client

A parent or guardian may sign an application/recertification for a minor client. In these cases, a parent should be listed as the parent/guardian on the application or recertification form and listed in the "Authorization to Release Information" section of the application/recertification.

Expired Signature Dates

Incomplete applications not completed within 60 days of initial receipt into ClientTrack will not be reviewed by the Program; the case management agency will be notified. A new application with supporting documentation will need to be submitted for review.

Filing an Appeal

If an applicant believes an error was made in determining eligibility, the client may appeal the determination decision by submitting a request in writing through their case management agency to the Program which includes justification of how they meet the eligibility criteria and any supporting documents. Submitting an appeal does not guarantee

approval. Eligibility requirements are not appealable, only the accuracy of the eligibility determination may be appealed.

Exception to Policy

The Program may approve an Exception Request when there is a demonstrated need. Examples of the use of an Exception Request include, but are not limited to, the following:

- Appeal Eligibility Determination
- Exception to a Program Policy
- Medication Acquisition for Travel or Moving
- Request exception from the vigorous pursuit mandate

Each Exception Request will be reviewed case-by-case with the Program making the final determination. Submission of an Exception Request does not guarantee Program approval. The Exception Request and determination, approval or denial, will be shared with the case management agency and retained with the applicant's file for Program records. Please allow at least one business day for review of an expection request.

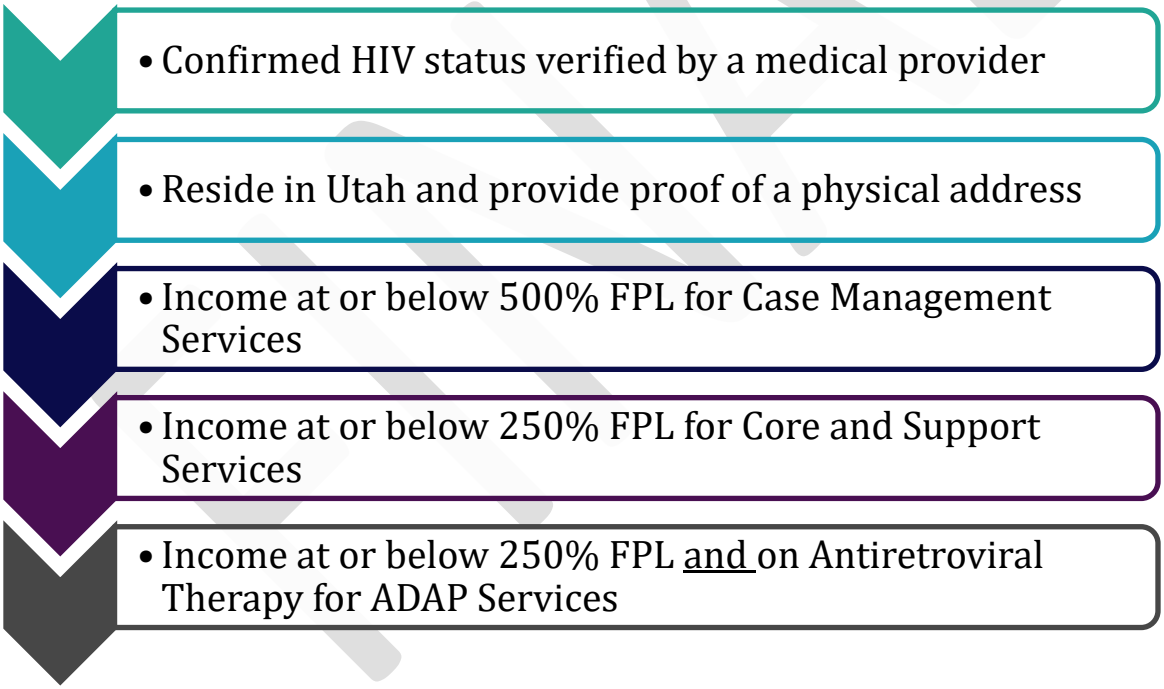
Expedited Review

The Program is commited to facilitate the rapid delivery of RWHAP services, Including the provision of antiretrvorials for those newly diagnosed or re-engaged in care. Expedited review may be granted if an applicant demonstrates an immediate medical need for approval to receive services. Same-day eligibility determination is not guaranteed and is not always possible. Please allow at least one business day for review.

ELIGIBILITY CRITERIA	Purpose: Provides an overview of eligibility requirements for the Utah Ryan White Part B Services Updated: September, 2022 Next Review: March, 2023 Owner: aallred@utah.org

ELIGIBILITY CRITERIA

Clients must meet all eligibility criteria for both individual and household requirements. Services may have additional criteria beyond the basic eligibility criteria listed below. Refer to Service Enrollment for additional information.



Enrollment into specific services may have additional criteria in order to qualify. Applicants are encouraged to work with their case management agency to understand all services they may qualify for and how to enroll.

ELIGIBILITY – HIV DIAGNOSIS

Updated: April, 2021

HIV Diagnosis

Applicants must have a confirmed HIV diagnosis verified by a medical provider. Proof of HIV diagnosis must be received directly from the provider or case management agency.

- Proof of HIV Diagnosis
- New Applicants must submit one of the following for HIV verification.
    - A statement of HIV diagnosis from a medical provider and signed by a physician.
    - Documentation of HIV diagnosis received from a physician, medical practice, laboratory, or transferring case management agency.
        i. A confirmed HIV status by laboratory documentation must be stated in a manner that Program staff without medical training may make a determination.
- Re-certifying clients
    - HIV Surveillance data may be utilized for re-certifying clients as determined by the Program.
    - Returning clients do not need to re-verify HIV diagnosis if Program already has record.

ELIGIBILITY– STATE RESIDENCY

Updated: September, 2022

Utah Residency

An individual is considered a Utah resident if they are voluntarily living in the state and intend to reside in the state. An individual who moves to Utah from another state and intends to become a Utah resident is a Utah resident regardless of the amount of time they have been in the state.

Applicants must be physically present or temporarily absent to be a resident of Utah. Citizenship is not relevant to the determination of state residency. PO Boxes are not acceptable as proof of residency; however, PO Boxes may be provided as a preferred mailing address in addition to proof of physical address.

Temporary absences after a person has been residing in Utah do not affect eligibility if the individual intends to return to Utah when the reason for the absence is accomplished. Services will not be terminated because of a temporary absence if the person intends to return to Utah, unless another state has decided the person is a resident in that state for the purpose of Part B or ADAP eligibility. Temporary absences may include illness, education, military service, business, vacation, etc.

The effective date for Part B services cannot begin until the day the individual arrives in Utah and intends to be a resident. Individuals not intending to be a resident of Utah, but rather visiting temporarily, are not considered residents and are not eligible for Utah Part B services.

Clients experiencing homelessness must work with a case management agency to provide acceptable documentation.

➢ Proof of Residency

Clients must demonstrate they are a currently residing in Utah. Proof of Residency documentation is not required to match client's mailing or physical address. PO Boxes are not acceptable as Proof of Residency but are allowable as current mailing address. For a

minor client, proof of residency may feature a guardian's name listed as the parent/guardian on the client's application or recertification.

Acceptable Documentation

All applicants must provide a copy of at least one of the following documents, when the Program is unable to verify residency through internal sources, which features the applicant name and Utah street address. Documents must not be expired more than two months from submission date unless otherwise specified.

Proof of Residency Documentation	Additional Criteria
Utah driver's license	*Cannot be expired more than two calendar months*
Utah State ID	*Cannot be expired more than two calendar months*
Tribal ID	*Cannot be expired more than two calendar months*
Paystubs or Earning Statement	*Dated within last two calendar months*
Documents issued by a financial institution	*Bank statement, credit card statement, etc dated within last two calendar months*
Current rental or lease agreement	*Signature pages and length of agreement must be included*
Recent utility bill	*Dated within last two calendar months. Cell phone bills are not accepted*
Current mortgage statement	*Dated within last two calendar months*
Most recent property tax document	*Dated within last 12 months*
Copy of SSI/SSDI Award Letter	*Current year benefit letter*
Document issued by the State of Utah	*Public assistance documents, tax documents, voter registration cards, vehicle title registration cards, etc. dated within current calendar year or within last two calendar months depending on document*
Document issued by the United States Federal Government	*Public assistance documents, tax documents, tax transcripts, etc. dated within 12 months.*

Military/Veteran's Affairs ID	*Cannot be expired more than two calendar months*
Approved letter from case management agency, homeless shelter, or transitional service provider	*Letter reviewed and approved by UDOH. Letter should be submitted on letterhead, be dated within last 60 days, have a signature and contact information.*
Internal sources used by the Program	*Utah residency will be verified by the Program using information available internal resources.*

Acceptable Proof of Residency for a Homeless Applicant

Individuals experiencing homelessness may designate a fixed location as their residence for identification purpose if it is an identifiable location in the state of Utah which could conceivably serve as a temporary residence. This location may be a homeless shelter, or other location where a homeless individual may spend time or return to.

In order to establish that a person without a traditional residence is a qualified Utah resident, the applicant needs to produce documentation showing a relationship to a particular shelter or agency. This form of documentation may include a letter from a shelter, private or public social service organization providing services for homeless individuals. The letter identifies the individual and describes the location designated as the persons' residence.

The identification letter should be on letterhead and signed by a person affiliated with the social services organization. See Appendix B for example.

ELIGIBILITY – INCOME

Updated: September, 2022

Household Income

The RWHAP legislation mandates that clients receiving treatment services be low-income as defined by the jurisdiction. Program eligibility is set by Utah Administrative Rule R388-805.

Program eligibility is determined from both individual and household income. Clients must meet all of the eligibility criteria as determined by the Program.

- "Household" includes the client (parent(s)/guardian(s) of minor client), the client's legal spouse, and the client's financial dependents including children. In the case of a minor client, "household" will include legal guardian(s) (parent(s)) and their financial dependents, including the minor client.

  If the client and legal spouse are separated, the spouse's income will not be counted towards the applicant's household size or household income. UDOH may require documentation of legal separation if necessary to determine eligibility.

  If an applicant is claiming an adult as a dependent, such as parents, UDOH may require documentation of dependent status to determine eligibility.

- "Household income" includes income earned by the client (parents/guardian of minor client) and the client's legal spouse. Married applicants are required to provide verification of spouse income. Income intended for a child is not counted towards household income, including but not limited to child support and benefits.

Asset limits

The Utah Part B Program no longer has an asset limit. This restriction was removed in 2016

What is Income?

Earned income *Cash, checks, direct deposits, etc. received for which a service was performed*		
Included *Required to be reported*	Income Type	Excluded *Not required to be reported*
Holiday, sick, and vacation pay. Employer contributions to HSA accounts.	Wages and Salaries	Certain employee benefits, such as payments to a retirement plan, medical insurance, and FICA taxes paid by the employer. Tax return refunds.
Payments made through contract work		In-kind services, including food or shelter, childcare, etc.
Tips, Commission, Wage Advances and Bonuses		Do not count allocated tips as income. The allocated amount is the amount reported by the employer to IRS based on gross receipts of the business.
Severance pay		Replacement of income that was lost or stolen
Training incentive payments and work allowances		Rebates, refunds, reimbursements or return of money, including per diem
Capital gains received from the sale or transfer of assets used in self-employment		Cash received from selling a car, etc.

	Self-Employment	Receipts from the sale, exchange, or replacement of resources
Profits received from Self-Employment		Personal services *Ex: Mowing the lawn, shopping, babysitting, housecleaning, or other similar services, which are done sporadically and without the intent to establish a self-employment business and render nominal amounts of money are not considered income.*
Unearned Income *Cash, checks, direct deposits, etc. received by an individual for which no service was performed.*		
Included *Required to be reported*	Type of Income	Excluded *Not required to be reported*
Withdrawals from Pensions and Retirement funds	Retirement	Pension and Retirement funds not currently being withdrawn.
Disability benefits, survivor benefits, life insurance benefits, VA benefits	Benefits	Credit life or credit disability insurance payments
Unemployment income, needs based income such as SSI		In-kind gifts, cash for medical or social services, including food or shelter, payments of bills by a third party Benefits intended for a dependent such as SSI
Alimony, Inheritances, Tribal Fund Payments, and Cash Gifts	Payments Received	Child Support
Rental income	Investments	Reverse equity mortgages

Certain business income, such as limited partner payouts and dividends		Proceeds from a bonafide loan
Education assistance including funds used for living expenses and non-education expenses. Work-study income that is reported as wages on tax returns.	Education	Funds used for tuition, fees, books, and supplies Education loans

- Proof of Income

Both earned and unearned income count towards the gross annual household income. Applicants should submit acceptable documentation for all income sources that the Program is unable to verify internally. Documentation must be dated within two calendar months of submission date unless otherwise specified. If an applicant is receiving payments from any source not listed they should work with their case management agency or the Program to determine if this income should be reported and what documentation is required.

- *Acceptable Documentation*

The following table provides examples of acceptable documentation for the most common types of income. Clients may submit documentation not included in this list for review and consideration by the Program. At a minimum, proof of income documentation must be dated, display the wage earner's name (client, spouse, etc.), and sufficient information to determine gross household income. Where possible the Program will verify a client's income through available internal sources.

Income Type	Acceptable Documentation
Wages and salaries from formal employment (*wages, tips, commission, etc.)*	*One of the following:* *The equivalent of one month's earnings dated within two months of submission for ALL jobs. (One month's earnings equals 2 paystubs if paid biweekly or 4 paystubs if paid weekly.)* *OR* *Most recent tax statements or W-2 Forms may be accepted if client is still employed with same company.* *OR* *Employer Statement displaying current wage, hours worked, pay frequency, and availability of benefits must be signed and dated within two calendar months of submission.*
Wages and salaries from informal employment with no paystubs *(cash earnings, day laborers, etc.)*	*Depends on source. Work with case management agency to determine most appropriate documentation.*
Self-Employment	*IRS Form 1040 and Schedule C or Schedule E for most recent tax filing period*
SSI/SSDI	*Current year benefit letter*

Benefits *(life insurance, disability, educational assistance, survivor's, etc.)*	*Current year benefit letter*
Capital Gains, Stocks, Bonds, Cash Dividends, Trust, Investment Income	*Tax Documentation for most recent period or documentation from financial institution*
Public Assistance / Unemployment	*Unemployment Statement, award letter or paystubs or General Assistance Letter from Department of Workforce Services (DWS) for current period*
Retirement *(pensions, annuities, 401k, etc.)*	*Current benefit statement*
Alimony	*Current benefit letter or other official documentation*
Rental Income	*Current rental agreement, tax documentation, or other official documentation*
Veterans benefits	*Current year benefit letter*
"Other" Income	*Depends on source. Work with case management agency to determine most appropriate documentation.*
Legal Spouse's Income	*See above for acceptable documentation by type of income*

- *Employer Statement*

The Program may accept an Employer Statement that provides sufficient information to determine gross annual household income. Preferred documentation is the Employment Verification Form (Appendix A) provided by the Program. At minimum, the Employer Statement must contain the following information:

- Client Name
- Current wage or salary
- Number of hours worked per week or pay period
- Frequency of pay
- Employment start date and length of employment, if time limited
- Name, title, and contact information of individual completing the statement
- Submitted on official letterhead when available
- Signed and dated within two calendar months of submission
- The Program may consider accepting email statements from employers. Emails should include all of the required information and be sent from a verifiable email address associated with the employer.

- *Affidavit of Zero Income*

If a client's household receives none of the listed sources of income they may complete the Affidavit of Zero Income. Clients receiving payments from the list of "Excluded" income sources are considered Zero Income.

ELIGIBILITY – HEALTH INSURANCE COVERAGE

Updated: September, 2022

HRSA PCN #13-02 states:

'RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source… Part B Program and contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible. (e.g. Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) …. The RWHAP will continue to be the payer of last resort and will continue to provide services not covered, or partially covered, by public or private health insurance plans. '

Assessment of Available Coverage and Vigorous Pursuit

The Program defines "vigorously pursue" as making a reasonable effort to enroll a client into health care coverage for which they may be eligible. Reasonable effort made by Part B contracted agencies should include all of the following:

1. Assessment of available coverage to the client, and
2. Education of the benefits of health insurance, and
3. Assistance in enrolling in health coverage.

Per HRSA PCN#13-02, a client may remain unenrolled in an eligible payer source and remain eligible for Part B Program services if extensive documentation of vigorous pusuit is provided with re-certification.. Documentation of efforts are outlined below.

Assessment of available health care coverage is determined during the initial application and each subsequent re-certification. Client responses to available payer sources in addition to the required documentation submitted by the client are utilized to determine if the client is currently enrolled or should pursue enrollment in other health care coverage. The Program reserves the right to request additional information as deemed necessary to verify accuracy and completeness of information provided by the client. If the client

becomes eligible or enrolls in other health care coverage during their eligibility period they may be enrolled in a different ADAP service to better serve their needs and provide cost-effective care.

Vigorous Pursuit

HRSA HAB requires that grantees must ensure that their sub-recipients and contractors are maximizing RWHAP resources by enrolling clients in a health care coverage option that is more cost-effective than paying the full cost for medications and other essential medical services. HAB requires grantees to maintain policies regarding the required process for the pursuit of enrollment for all clients, to document the steps during their pursuit of enrollment for all clients, and establish stronger monitoring and enforcement of subrecipient and contractor processes to ensure that clients are enrolled in Medicaid if eligible.

RWHAP funds, including AIDS Drug Assistance Program (ADAP) funds, may only be used to continue to pay for private health insurance for Medicaid-eligible clients if it is more cost-effective to do so and in accordance with RWHAP policy. PCN 13-02

The Utah Ryan White Part B Program shall require that affordable insurance is vigorously pursued for all clients seeking ADAP services. Clients for whom vigorous pursuit is not provided will not be eligible for continued ADAP services.

All Medicaid-eligible clients will need to vigorously pursue Medicaid, except if otherwise approved by the program. If a Medicaid-eligible client is not enrolled vigorous pursuit documentation needs to be provided to the program by the contracted agency. Vigorous pursuit includes but is not limited to extensive records documenting insurance education and efforts to apply for Medicaid. Clients enrolled in certain Medicaid programs are eligible for the Program as long as the Program can verify enrollment and a spendown is not required.

Other Health Care Coverage

The following table provides examples of minimum effort and documentation required to demonstrate vigorous pursuit for the most common types of Health Care Coverage. The Program may request documentation not listed below to verify availability of other payer

sources. The Program will use available internal resources to verify other Health Care Coverage.

Type of Coverage	Assessment of Availability	Vigorous Pursuit Documentation options
Medicaid	All Medicaid-eligible clients will need to vigorously pursue Medicaid, except if otherwise approved by the program. If a Medicaid-eligible client is not enrolled vigorous pursuit documentation needs to be provided to the program by the contracted agency. Vigorous pursuit includes but is not limited to extensive records documenting insurance education and efforts to apply for Medicaid Clients may continue to receive Part B services while Medicaid enrollment is pursued. All available charges will be back-billed to Medicaid once the client is approved. Primary Care Network (PCN) is considered insufficient coverage as it does not provide comprehensive HIV medical care. Clients enrolled in PCN are considered under-insured and qualify for all Program services, including health insurance.	• Proof of Medicaid enrollment • Proof of submitted Medicaid application-. Multiple submitted Medicaid applications without a decision will not be accepted without additional explanation as to why initial application was not accepted, follow-up documentation required. • Agency provides documentation of insurance education and efforts to assist the client in enrolling in Medicaid. • Agency provides documentation of insurance education and efforts of client to enroll in Medicaid

Medicare Part D	Clients eligible to enroll in Medicare Part D or other Medicare pharmacy benefit plan are encouraged to pursue enrollment. Case management agencies are responsible for assisting clients with their enrollment and may assist clients in requesting the Program to assist with paying monthly premiums.	• Proof of enrollment into Medicare Part D insurance • Agency provides documentation of insurance education and efforts to assist the client in enrolling in Medicare Part D including documentation of efforts to remind client of group insurance open enrollment and assistance during open enrollment. • Agency provides documentation of insurance education of client efforts to enroll in Medicare Part D
Group Plan – Spouse or Parent	Program will request information regarding current enrollment or eligibility to enroll in spouse or parent health insurance coverage. If client is eligible for coverage and not enrolled, the case management agency is expected to vigorously pursue client enrollment. If the client is eligible for dual coverage through a spouse/parent	• Proof of enrollment into Group insurance • Agency provides documentation of insurance education and efforts to assist the client in enrolling in Group insurance including

	plan and an employer plan, the Program requests, but cannot require, that the client enroll in both plans. The Program will not require Proof of Insurance Availability from spouse or parent employer due to confidentiality reasons. Program cannot require a client to enroll into a health plan. The client may decline to enroll in a group plan and remain eligible for Program services if vigorous pursuit requirements are met . (HRSA PCN#13-03 and #13-04).	documentation of efforts to remind client of group insurance open enrollment and assistance during open enrollment. • Agency provides documentation of insurance education of client efforts to enroll in Group insurance
Group Plan – Client Employer	Program has the responsibility to verify if a client is currently enrolled in an employer plan. Current enrollment is verified through a variety of sources which may include, but is not limited to: client report, review of paystubs for health insurance deductions, documentation from the employer, and health insurance verification conducted by Pharmacy Benefits Manager. Program has the responsibility to request information regarding client eligibility for employer coverage. If client reports they are not eligible for employer insurance, the Program may request additional information or documentation as needed to complete determination. Client is employed and enrolled in employer health insurance:	• Proof of enrollment into Group insurance • Agency provides documentation of insurance education and efforts to assist the client in enrolling in Employer insurance including documentation of efforts to remind client of employer insurance open enrollment and assistance during open enrollment. • Agency provides documentation of insurance education of client efforts to

	• Documentation of plan details will be requested once annually for continuous employment
	
	Client is employed but not enrolled in employer health insurance:
	
	• If a client reports they work less than 30 hours per week, which is verified with pay statements, and
	  • Client reports insurance is not available to them, Proof of Insurance Availability will not be required from the employer, or
	  • Client reports insurance is available to them, Proof of Insurance Availability will be required from the employer
	
	• If a client reports they work more than 30 hours per week, which is verified with pay statements, Proof of Insurance Availability will be required from the employer
	
	Proof of Insurance Availability will be requested once annually for continuous employment.
	
	Program cannot require or enforce client enrollment into a health plan. The client may decline to enroll in an employer-sponsored health plan and remain eligible for Part B services, however, vigorous pursuit documentation must be provided to continue to be elgible for ADAP services.
		enroll in Group insurance

COBRA	Clients eligible for COBRA are encouraged to pursue enrollment to maintain continuous health coverage, however, clients eligible for COBRA also qualify to enroll in a Program-sponsored DPI plan. Clients should work with their case management agency to determine the most appropriate plan to enroll in.	Vigorous pursuit not required
DPI	Clients eligible for DPI are encouraged to pursue enrollment during yearly open enrollment or if the client has a Special Enrollment Perioed due to a Qualifying Life Event. . Clients should work with their case management agency to determine the most appropriate plan to enroll in.	• Proof of DPI enrollment • Agency provides documentation of insurance education and documentation of efforts to contact client before and during open enrollment • Documentation of insurance education and explanation of why client, although contacted and educated is not a good fit for insurance benefits

Exceptions to the Payer of Last Resort Requirement

RWHAP recipients may not deny services, including prescription drugs, to an individual receiving benefits through Veterans Affairs (VA) who is otherwise eligible for RWHAP services, even if they could obtain services and medications through the VA (PCN 16-01). Native Americans can also access RWHAP services, including prescription drugs, even if

those services are available through Indian Health Service, tribal or urban Indian health programs (PCN 07-01).

The Ryan White Program reserves the right to request additional information if extensive documentation is not received.

Incarcerated Individuals Living with HIV/AIDS

The Utah State Prison provides HIV medical care therefore Program services are prohibited due to the statutory payer of last resort. The Program may provide case management services for clients incarcerated in Federal and State prison systems on a transitional basis only as far as the incarceration facility will allow.

The Program can provide eligible clients with ADAP-M, Medicaid Copay, outpatient ambulatory medical care, if seen at an OAMC contracted facility, and case management services for individuals incarcerated in other correctional systems including those under community supervision as far as the incarceration facility allows on a short-term and/or transitional basis. Confirmation must be received from the facility that duplication of services is not being provided. The Program cannot pay for services for incarcerated persons who retain private, State or Federal health benefits during the period of their incarceration.

Clients must maintain Program eligibility. Confirmation that duplication of services is not being provided is required for services offered on both a short-term and transitional basis. An estimated date of release must be received by the Program to determine if the client is eligible for services on a transitional basis.

To be an allowable cost, an explicit connection between any service supported by the Program and the HIV care and treatment of the incarcerated person and must adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV

The Program may only be used to support PLWH who are incarcerated and expected to be eligible for Program services upon their release.

Upon the date of release clients may begin receiving all other core and support services offered by the Program as long as Program and service eligibility is continued. Additional core and support service applications may be received and determined by the Program prior to the client's release. If approved, these additional services will not become effective until the date of release.

ELIGIBILITY – AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Updated: September 2022

ADAP Eligibility

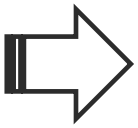
In addition to meeting the minimum eligibility criteria, applicants must be currently taking or intending to begin Antiretroviral Therapy to qualify for ADAP services. Clients who do not utilize ADAP to purchase their medications may be disenrolled from ADAP.

- Enrollment Criteria

Depending on the client's life circumstances, they may qualify for different ADAP services.

ADAP Program	Enrollment Criteria
ADAP-M	Clients who are uninsured or underinsured
ADAP-I: COBRA	Clients who are currently enrolled or eligible to enroll in COBRA.
ADAP-I: Direct Purchase Insurance (DPI)	Clients who are not currently enrolled or not eligible for enrollment into a Group Plan or Medicaid. Some exceptions apply.
ADAP-I: EB-HIPP *(Employer)*	Clients who are currently enrolled or eligible to enroll in a group plan through an employer
ADAP-I: Group Plan	Clients who are currently enrolled or eligible to enroll in a group plan through a spouse or partner's employer, or a parent's employer
ADAP-I: Marketplace	Clients who are currently enrolled in a Marketplace plan.
ADAP-I: Medicaid	Clients who are currently enrolled or eligible to enroll in Medicaid.
ADAP-I: Medicare Part D	Clients who are currently enrolled or eligible to enroll in Medicare Part D or other Medicare pharmacy plan.

Employment and **Health Insurance Status** will determine the most appropriate ADAP service for a client.

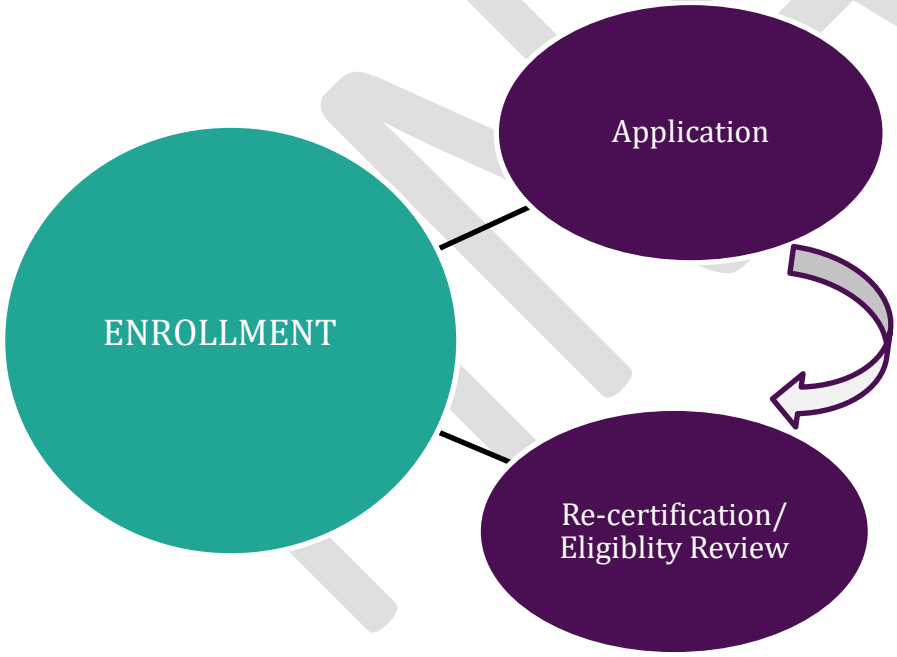


	INSURED	UNINSURED
EMPLOYED	EB-HIPP Group Plan Medicare COBRA Marketplace	ADAP-M DPI Medicaid
UNEMPLOYED	Group Plan Medicare COBRA Marketplace	ADAP-M DPI Medicaid

APPLICATION , RECERTIFICATION, AND ELIGIBLITY REVIEW	Purpose: Provides an overview of how to access Program services and maintain enrollment. Updated: September 2022 Next Review: March, 2023 Owner: aallred@utah.gov

APPLICATION, RECERTIFICATION AND ELIGIBILITY REVIEW POLICIES

Clients applying for the Program will have their eligibility reviewed for all Program services they may qualify for, including ADAP. Clients are approved for a twelve month eligibility period at the end of which they will need to re-certify for the next eligibility period.



Applications are accepted at any time for initial enrollment.

Recertification or an Eligiblity Review is required every twelve months after initial enrollment.

Applications

New applicants must submit an Application Form which includes HIV diagnosis verified by a medical provider.

New applicant is defined as an individual who has not previously received services from the Program. Eligibility is determined by Program staff; the applicant and case management agency willbe notified of eligibility determination. New applicants will be approved for up to twelve months of eligibility from the application date.

Annual Recertification and Recertification or Eligibility Review

To maintain eligibility for Program services, clients information must be verified every twelve months. The Program will use internal sources to verify client information. Requests for information that is unable to be verified by the Program will be sent to the client and the partner agency providing benefits and eligibility care.

A client who has previously been disenrolled from the Program will need to recertify regardless of how long they have been disenrolled.

- Re-certification Application
  - A comprehensive re-certification can be required up to once annually.
  - Clients who have been disenrolled will be required to submit a Re-certification.
  - For clients without a gap in services, the Program will use available internal sources to verify Program eligibility
  - A client is able to opt out of the Program using internal resources.
  - All clients will need Sign the Rights and Responsibilities Statement annually.
  - A client will be asked to provide any information unable to be verified by the Program
    - The Program will begin verifying client eligilbity in the beginning of the 10th month of their eligibility for any information that is unable to be verified by interal resources. The client will work with the Program and/or Program partners to provide requested information. Requested information will need to be received by the 12th month of the client's eligibility period to avoid a gap in coverage.
      - The Program and/or Program partners will contact client by mail, email and/or telephone at least 3 times. Contact attempts will be documented in Client Track.

- If no response is received from the client by the end of the clients' 12th month of eligibility, the client will be disenrolled from the Program.
- If a client is disenrolled due to a no response a client will need to submit a recertification to be re-enrolled and the Program will not be able to use any internal sources to assist with recertification.

○

➢ Application Period
Recertifying clients will be asked to submit information not verifiable by the Program during the 10th month of their eligibility period.

➢ Review Period
UDOH requires a minimum of 30 calendar days after submission of requested recertification documentation to review and determine client eligibility. Clients are strongly encouraged to submit their requested information in the11th month of their eligibility period to allow sufficient time for eligibility determination to prevent a gap in services. Part B Program services will not extend beyond the client's eligibility end-date until the application has been approved by UDOH.

Required Documents

In addition to the Application Forms, clients must submit acceptable documentation demonstrating eligibility for Program services, when requested. For a list of acceptable documents, refer to the Eligibility section of this manual.

Reporting Changes

Client eligibility is based on current life circumstances. Any changes should be reported to the case management agency and the Program as soon as the client is able. Certain changes may impact what types of services the client may qualify for. If a client intentionally withholds information about changes their services may be suspended or terminated.

Changes in Eligibility Criteria	What to Report	When
Insurance Coverage	• New health coverage • Loss of health coverage • Plan cost (premium)	As soon as possible Changes to your insurance can result in you owing money to the insurance company or to the Program. Notify the Program immediately of any changes to your insurance or if you become eligible for different insurance.
Residency	• Change in address • Moving out of state.	As soon as possible Report any change in address as soon as possible as this may impact the Program's ability to communicate with you. A change of address within the state of Utah does not impact eligibility. Moving out of state requires immediate notification to the Program.
Household Size	• Change in marital status (marriage, divorce, legal separation) • Change in number of dependents	Re-certification / Self Attestation

Household Income	• Loss of income • New income • Amount of income (decrease or increase)	Re-certification / Self Attestation * *Proof of Insurance Availability may be requested if employment changes*

Failure to report

If a client is determined by the Program as failing to report changes in available health care coverage, as defined by policy, the Program reserves the right to limit the services the client may qualify for.

- Failure to report is defined by the Program as any one of the following:
  - Client did not take appropriate action to notify the Program, case management agency, case manager, or benefits specialist of a change in health insurance availability or health care coverage; or
  - Client misrepresented information provided to the Program.
- If the Program determines that the client meets any of the above criteria, the client may have service restrictions or limitations for their next eligibility period up to 12 months.
- The client would qualify for ADAP and services designed to support medical care, such as CSA, Medical Transportation, and Case Management.
- The client would not qualify for Support Services, including EFA, Food Vouchers, and Oral Healthcare.
- The Program would notify the client and their case manager of the restriction of services.
- The client may become eligible and enrolled in all Program services at their next recertification given that they meet all other eligibility.
- Case manager may request restrictions be removed after six (6) months following notification of service restriction.
  - Request from case manager must be in writing and with the following elements

i. Statement of client education for reporting future changes to the Program.
ii. Statement of need for support services not directly related to medical care access.

- Clients who fail to report changes to the Program in excess of three instances may be permanently restricted from accessing support services not directly related to medical care access.

SERVICE ENROLLMENT POLICIES	Purpose: Provides overview of how eligibility is determined for service enrollment. Updated: September , 2022 Next Review: March, 2023 Owner: aallred@utah.gov

SERVICE ENROLLMENT

The Program will only review and evaluate complete applications. Only Program staff may determine client eligibility. All applications, re-certifications, must be complete and submitted to the Program within 60 days of the applicant (parent/guardian of minor client) signature date.

Application Date

- The date a complete application is received by the Program. This must be within 60 days of the start of a new application or the beginning of a draft.

Determination Date

- The date eligibility determination is conducted and results in an approved or denied status.

Eligibility Start Date

- The date the client's eligibility period begins. For clients re-certifying without a gap in services, this is often the first day of the new eligibility period. For new clients or clients re-certifying after a gap in services, this is often the application date.

Enrollment Date

- The date the client begins receiving specific Program services. Clients may have changes in service enrollment throughout their eligibility period. Service enrollment may not exceed the eligibility period.

Eligibility Period

- Up to twelve months continuous eligibility from the eligibility start date through the last day of the twelfth month, with a few exceptions. Once a client is determined to be eligible, they remain eligible for the remainder of their eligibility period. Exceptions to the 12 month eligibility are: client is no longer a Utah resident, the client requests to be disenrolled, or the client is deceased. Client service enrollment may vary throughout their eligibility period.

Eligibility End Date

- The last day of the client's eligibility period. Generally, this is the last day of the month twelve months after eligibility start date.

Eligibility Periods

Once approved, clients are eligible from their eligibility start date through the last day of the twefth month of their eligibility period. The eligibility period is twelve months of continuous eligibility with a few exceptions: the client is no longer a Utah resident, the client requests to be disenrolled, or the client is deceased. Changes potentially impacting eligibility will be determined during the client's next re-certification. . The Program will not accept recertification applications prior to the 10th and 11th th month

Utah Part B Program Recertification Schedule *Eligibility Periods may not exceed twelve months. Clients may recertify in the 10th month of their current eligibility period*		
Eligibility Start Month *Month One of Eligibility*	Eligibility checks start Month *Month Ten of Eligibility*	Eligibility End Month *Month Twelve of Eligibility*
January	October	December
February	November	January
March	December	February
April	Janaury	March
May	February	April
June	March	May
July	April	June
August	May	July
September	June	August
October	July	September
November	August	October
December	September	November

Service enrollment changes may occur within the twelve month eligibility period and may require the submission of documentation to qualify for additional services. For example, a client may enroll in ADAP-M in month one and later enroll in a Group Plan through their employer in month four. Service enrollment changes do not re-start a client's eligibility period. Clients must re-certify for the next eligibility period to continue receiving services. Clients will be contacted in the 10th month of their eligibility period and will need to submit requested information by the end of the 12th month to avoid a gap in service enrollment.

If a client does not re-certify during their eligibility period, they will be disenrolled. If they re-certify after experiencing a gap in services, their eligibility period begins with their new application date and does not continue from their previous eligibility period.

Service Enrollment and Activation

Clients who are eligible for the Program may have changes in service enrollment throughout their eligibility period. Service enrollment may begin as early as the application

date, except for Case Management which can start once an application is started in Client Track. If a client has a life changing event and qualifies for different services than they were originally approved for, the client may be required to provide documentation prior to being enrolled in additional services.

Case Management Services

All approved clients qualify for and will be enrolled in Case Management services. Eligibility for Case Management services will be considered effective as of the eligibility start date, if there is a gap in services, through the end of the eligibility period once the application is approved. Case Management services will not be covered for applicants who are not approved.

Clients who submit an application for only Case Management services will have their eligibility criteria reviewed for all services and may be enrolled in Support Services if they qualify. If the client qualifies for ADAP, they will be approved for ADAP but will not be enrolled unless requested.

ADAP, Core Medical, and Support Services

Eligibility for ADAP, Core Medical, and Support Services will be considered effective as of the eligibility start date through the end of the eligibility period or once the client qualifies and is approved. All clients must be approved by the Program prior to payment of any services.

Services provided during eligibility determination that require payment at time of service (e.g. medications) or any service covered by another payer source cannot be covered by the Program. Any service provided during eligibility determination to a client who is not approved will not be covered by the Program.

COBRA

Services provided to a client between the retroactive date of COBRA coverage and the date the client is enrolled in COBRA will be back-billed when possible. For services that do not have another payer source or that COBRA will not cover, such as pharmacy services, the Program will not pursue reimbursement of funds from the client. Clients who are eligible for COBRA also qualify to enroll in a Program-sponsored DPI plan. Clients should work with their case management agency to determine the most appropriate plan to enroll in.

Retroactive Medicaid

Providing temporary assistance to Program eligible applicants while Medicaid eligibility is determined is allowed, with the clear understanding that Medicaid is back-billed for Medicaid covered services upon determination. (HRSA PCN #13-01)

Medicaid enrollment is verified during initial eligibility determination and at each re-certification or elibility review Clients who fail to report enrollment into Medicaid as determined by policy may be subject to the Failure to Report policy found in the Application and Recertification section of this manual.

All Medicaid-covered ADAP-M pharmacy services provided between the retroactive date of Medicaid coverage and the date the client is Medicaid enrolled will be back-billed to Medicaid.

In cases that will not cause potential client harm, such as after a client has reached their maximum-out-of-pocket (MOOP), ADAP-I services that are Medicaid covered that were provided to a client between the retroactive date of Medicaid coverage and the date the client is enrolled in Medicaid will have charges reversed and Medicaid services back-billed. ADAP-I services provided during this same time period that Medicaid does not cover or only partially covers, such as health insurance premiums, medical co-pays, and deductibles cannot be back-billed to Medicaid and recoupment will not be pursued from the client in order to prevent harming the client's overall health, well-being, and engagement in care.

RIGHTS AND RESPONSIBILITIES	Purpose: Provides an overview of the behavior agreements between Program, providers, and clients. Updated: April, 2019 Next Review: March, 2023 Owner: aallred@utah.gov

Clients Rights and Responsibilities

Clients are required to review and agree to the Rights and Responsibilities upon initial application and each subsequent recertification which establishes how clients can expect to be treated and what the Program expects from them. (Appendix C and D)

Service Provider Guidelines and Responsibilities

Part B Program Providers are expected to:

- Verify applicant enrollment status and eligibility prior to providing services. Questions regarding enrollment status and eligibility can be directed to the Program by calling (801) 538-6191 OR via email RWP@utah.gov.
- Assist applicants in applying and re-certifying for services; ensure only complete applications are submitted.
- Verify insurance, public and private, status for all new applicants and for clients during each re-certification period.
- Vigorously pursue enrollment into health care coverage for which clients may be eligible (i.e., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer sponsored health insurance coverage, and/or other private health insurance). Thoroughly document all efforts taken to pursue enrollment and outcome of those efforts.
- Assure that individual clients are informed about the consequences for not enrolling in other health coverage for which they are eligible.
- Ensure applicant/client confidentiality.
- Not supplant other funds with Ryan White Part B funds, or submit billing statements for Part B services covered by another program, (i.e. Medicaid, Medicare, any private or public insurance program, etc.), even if the provider is not a participating provider with said program.
- Maintain applicant/client and service data records.
- Submit the appropriate documentation with each billing cycle; including, but not limited to, documentation that billed services are for enrolled clients only.

- Participate in an annual monitoring visit and other monitoring visits as scheduled by the Program.
- Participate in any needs assessment and/or evaluation process conducted by the Program, UDOH, or its designee (i.e., quality management contractor).
- Comply with agreements with the Program (i.e., grant agreements, contracts, memorandums of agreement [MOAs], etc.).
- Participate in Program hosted meetings as required or invited.
- Ensure agency representation at quarterly Utah HIV Planning Group meetings.

UTAH AIDS DRUG ASSISTANCE PROGRAM (ADAP)	Purpose: Provides overview of the Utah ADAP Updated: April, 2020 Next Review: March, 2023 Owner: aallred@utah.gov

Utah ADAP

Purpose

The Utah Program provides two ADAP services: ADAP-Medication Assistance (ADAP-M) and ADAP-Health Insurance Assistance (ADAP-I). The "Utah ADAP" refers to both services unless otherwise specified.

ADAP-M

The purpose of ADAP-M is to:

- Facilitate access to medications that prolong life or prevent the serious deterioration of health, and
- Provide cost-effective drug therapy for those affected by HIV and AIDS and who are uninsured. Medications used to manage HIV and AIDS are costly and many PLHIV in the United States are unable to pay for these medications without ADAP-M assistance.

ADAP-I

The purpose of ADAP-I is to:

- Assist individuals in maintaining the continuity of medical services established through their health insurance coverage, including HIV and AIDS medication(s),
- Assist low-income PLHIV, who are not eligible for other insurance coverage, to access medical services and medication(s) by funding monthly health insurance premium payments and pharmacy deductibles and pharmacy co-payments, and
- Reduce the fiscal impact of HIV and AIDS on publicly-funded programs.
- ADAP-I includes the following services:
    - COBRA
    - Direct Purchase Insurance (DPI)
    - Employer-based health insurance premium payment (EB-HIPP)
    - Marketplace
    - Medicaid
    - Medicare Part D or other Medicare pharmacy benefits

- Group Plan through spouse or parent

The Utah ADAP may also provide services that enhance access to, adherence to, and monitoring of medication treatments with appropriate HRSA/HAB approval.

Client will qualify for different ADAP Programs and services depending on their unique life circumstances.

Overview

The Utah ADAP services are administered through the Program at UDOH. The main responsibility of ADAP is to authorize the provision and payment of HIV related medications, and/or health insurance premiums, pharmacy deductible payments, and co-payments for eligible individuals.

Specifically, ADAP is responsible for the following:

1. Authorizing appropriate medications;
2. Authorizing payment for prescribed medications;
3. Authorizing payment for health insurance premiums, pharmacy deductible-payments, and pharmacy co-payments through an ADAP-covered health insurance plan including COBRA, EB-HIPP, Medicaid, Medicare Part D, Private-Individual (DPI), and/or the Health Insurance Marketplace;
4. Authorizing payment for pharmacy deductibles and pharmacy co-payments for eligible clients enrolled in a private, employer, spouse, or parent health insurance plan; and
5. Maintaining client confidentiality.

ADAP Enrollment

New applications are accepted at any time. Once approved, a client is eligible for up to twelve months. Clients must re-certify for each eligibility period to continue receiving services. For eligibility requirements please refer to the Eligibility section of this manual. Additional requirements specific to ADAP-M and ADAP-I are outlined in the following sections.

Utah HIV Planning Group: ADAP Advisory Subcommittee

The purpose of the Utah ADAP Advisory Subcommittee, which convenes as part of the Utah HIV Planning Group (UHPG), is to make recommendations to the Program regarding ADAP

policies to ensure that PLHIV in Utah have access to HIV-related medications which will decrease morbidity and increase their quality of life. The Utah ADAP Advisory Subcommittee considers topics such as medications on the formulary, funding issues, cost containment activities, etc.

Reports and Program Evaluation

The Program prepares and submits the ADAP Data Report (ADR) to HRSA/HAB annually. The ADR enables HRSA/HAB to evaluate the impact of ADAP on a national level, inclusive of describing who is using the Program, what ADAP-funded services are being used and the associated costs with these services.

Wait-List

In the event the Program does not have adequate funding to support all currently enrolled clients for ADAP services, eligible applicants, new or re-certifying, may be placed on a wait-list.

ADAP-Medication Assistance (ADAP-M)
Updated: Septemeber 2022

ADAP-MEDICATION ASSISTANCE (ADAP-M)

Clients who are eligible for ADAP-M services through the Program are able to access medications on the Utah ADAP-M Formulary. Every ADAP is required to include at least one drug from each class of HIV antiretroviral medications on their formulary, but each state may determine the specific FDA-approved drugs to cover. ADAPs must follow HHS HIV/AIDS treatment guidelines on the management of HIV/AIDS disease. Guidelines cover multiple aspects of treatment, including the use of antiretroviral therapies and medications for opportunistic condition(s), prophylaxis, and treatment. ADAP-M clients needing assistance with medical visits and healthcare costs will be enrolled in Outpatient/Ambulatory Health Services.

Eligibility

For eligibility requirements please refer to the Eligibility section of this manual. If a client is not intending to start taking medications or not currently taking medications on the Utah ADAP-M Formulary, they will not be enrolled in ADAP-M services.

Clients who qualify for ADAP-M are generally:

- Uninsured or under-insured clients who cannot enroll or decline to enroll in ADAP-I
- Clients who need gap coverage between insurance policies
- Clients with private insurance that is not cost-effective, as determined by the Program, compared to ADAP-M services
- Clients with private insurance for which the formulary does not cover HIV medications or does not provide access to HIV medical care
- Clients with Veteran Affairs (VA) benefits
    - The Program policies do not consider VA health benefits as the veteran's primary insurance. The Program is aware of and is consistently implementing the veteran classification policy by classifying veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payer of last resort" requirement (HRSA PCN# 16-01).
- Clients with access to insurance are expected to understand the potential consequences of not enrolling in health care coverage for which they are eligible.

including the "individual shared responsibility payment" enforced by the federal government. The Program cannot help pay for any fees or penalties associated with remaining uninsured.

- In the event the Program does not have adequate funding to support all currently enrolled clients for ADAP services and a wait-list is implemented, then clients who declined health insurance available to them may have their place on the wait-list affected by this choice.

Medication Acquisition

Clients receiving ADAP-M services must access medications from a University of Utah pharmacy.

Mail-order medication services are intended to reduce barriers to accessing medications and promote treatment adherence to HIV treatment. The Program may cover postage for mail-order medications on the ADAP-M formulary. All ADAP-M clients are eligible for mail-order medications and should work with their provider or case manager to access this service.

Medications are mailed by the University of Utah Redwood Pharmacy and University of Utah Hospital Pharmacy. The Program does not authorize the mailing of medications to an out-of-state address, even in the case of extended absence out of state, or to individuals who do not reside in the State of Utah.

During a client's eligibility period, ADAP-M will provide one 30-day supply at a time of the client's prescribed medication(s) included on the Utah ADAP-M Formulary. Exceptions to the 30-day supply limit may be made for the following circumstances. Please allow at least one business day for processing:

- Moving – an enrolled client may be eligible to receive one additional 30-day supply of medication(s) if they are moving outside of Utah and services may be interrupted. The client must fill medications while currently residing in Utah and prior to moving out of state. Medications are not provided to those already living outside of Utah or using a mailing address outside of the state. Clients should provide notice to the Program at least five (5) business days prior to the move; a same-day request for expedited approval to accommodate moving plans may not be sufficient time for approval.

Vacation- an enrolled client may be eligible to receive one additional 30-day supply of medication(s) if they have a scheduled vacation in which medications may run out. Clients should provide notice to the Program at least five (5) business days prior to the vacation; a same-day request for expedited approval to accommodate vacation plans may not be sufficient time for approval.

To qualify for an exception to the medication acquisition policy, the case manager must submit an Exception Request detailing the justification for the exception to the Program via secure e-mail to RWP@utah.gov. Each Exception Request will be reviewed case-by-case with the Program making the final determination. Submission of an Exception Request e-mail does not guarantee Program approval. The Exception Request and determination, approval or denial, will be shared with the case management agency and retained with the applicant's file for Program records.

The Program will not replace lost or stolen medications.

Co-infected Tuberculosis Treatment

If an enrolled client is dually infected with active tuberculosis (TB) disease, then the Program will cover the cost of both ADAP Formulary medications and the client's TB medications (regardless whether or not those TB medications are on the Utah ADAP Formulary). This is an agreement between the Program and the TB Control Program within the UDOH.

Termination

Clients will be terminated from ADAP-M services if they become eligible for drug therapy coverage under another program or payer source.

Applicants and clients who purposely misrepresent their coverage by private health insurance, income and/or any other eligibility determination information may be terminated temporarily or permanently from the Program, including Core Medical, ADAP-M, ADAP-I, and Support Services. If deemed necessary, the Office of the Attorney General may initiate action against such individuals in order to recover costs associated with covering such clients.

ADAP-Insurance Assistance (ADAP-I)
Updated: September 2022

ADAP-INSURANCE ASSISTANCE (ADAP-I)

ADAP-I provides health insurance premium and cost sharing assistance for eligible clients. The Program, as stated in HRSA PCN #13-05 is, "expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance)". All applicants should be assessed for health insurance coverage during eligibility determination and at each re-certification and if eligible for insurance, the Program has the expectation that a client will enroll in health insurance that is available to them. (See Assessment of Available Coverage).

ADAP-I Includes the following:

- COBRA
- Direct Purchase Insurance (DPI)
- Employer-based health insurance premium payment (EB-HIPP)
- Marketplace
- Medicaid
- Medicare Part D
- Group Plan (spouse/partner or parent)

The Program provides the following health insurance premium and cost sharing assistance:

- Monthly premiums for qualifying health insurance plans
- Pharmacy deductibles, co-payments and/or co-insurance for medications on the ADAP-I formulary
- Medical deductible, co-payments and/or co-insurance for medical care related to the treatment of HIV

The type of ADAP-I assistance a client receives is determined by the type of health insurance coverage they have. The Program does not cover health insurance premium payments for group plans through a spouse, partner or parent; only employer-based, Medicare Part D, and DPI premium payments are covered by the Program. The Program expects a client to enroll in a health insurance plan that they are eligible for and is most cost effective for the Program. Clients who are eligible to enroll in a health insurance plan

but who choose not to may be enrolled in ADAP-M services if all other eligibility requirements are met.

Eligibility

For eligibility requirements please refer to the Eligibility section of this manual. If a client is not intending to start taking medications or not currently taking medications on the Utah ADAP-I Formulary, they are not eligible for ADAP-I services. All eligible clients with access to health insurance are considered eligible for ADAP-I services. Clients who decline available insurance coverage may be restricted from certain support and ADAP services, please refer to the Vigourously Pursue section within this manual.

Open Enrollment

All eligible clients without access to insurance through an employer, parent, or spouse are expected to enroll in a QHP during open-enrollment, which occurs annually, beginning in November, as decided by CMS. The Program reviews all QHPs in the jurisdiction for access to HIV providers, classifications and cost of HIV medications, and cost-effectiveness for the Program. If a client enrolls in a QHP that does not meet the Program criteria for minimum access to HIV treatment and care, the Program may choose to not provide premium or cost-sharing assistance.

Special Enrollment Period

After the open enrollment period ends, clients are not able to enroll in a QHP unless they qualify for a special enrollment period. If an eligible client has a qualifying life event during the calendar year in which they become eligible for enrollment in a QHP, then ADAP-I services will become available and the client is expected to enroll in a QHP. The Program may conduct a cost-analysis to determine if the QHP is cost-effective compared to ADAP-M services.

Health Insurance Premium Payment Assistance

ADAP-I provides health insurance premium payment assistance for eligible clients enrolled in a private-individual health insurance plan, employer-based health insurance plans, or a Medicare Part D plan. The Program considers private-individual insurance coverage to include:

- COBRA
- Employer-Based Health Insurance (employee portion only)
- Health Insurance Marketplace (Marketplace) QHP

- Direct Purchase Insurance (DPI) QHP

If a client is the policy holder or a dependent on a private double or family plan (not through an employer), then ADAP-I provides premium payment assistance for the client's portion of the premium only. For employer-based coverage when the client portion of the premium is not able to be calculated, ADAP-I may cover the employee's portion of the full policy premium. For more information see the Employer-Based Health Insurance section below.

If a client is deemed eligible for Medicaid, they may need to show proof of vigorous pursuit of Medicaid before a Premium Payment can be made. Premium payments are available to clients while vigorously pursuing Medicaid and while awaiting a Medicaid enrollment decision.

❖ COBRA

COBRA requires group health plans (i.e., employers) to provide temporary continuation of group health coverage to covered employees, their spouses, former spouses, and dependent children when group health coverage would be lost due to loss of employment.

The Program can help pay for:

- health insurance premiums
- pharmacy deductible
- pharmacy co-payments
- cost-sharing assistance

Eligibility

- If a client is newly eligible for COBRA, the Program agrees to conduct a cost-analysis between COBRA coverage and a Program-approved QHP to determine the most cost-effective option for the Program; length of requested assistance will also be considered.
- Since COBRA premium and pharmacy deductible amounts vary from plan to plan, and QHP premium amounts are affected by the client's income, the Program will conduct a cost-analysis for each client. If a client does not obtain a new employer-based insurance plan before the COBRA coverage has expired, the client should enroll in a Program-approved QHP that they are

eligible for; either through the Marketplace or direct purchase with the insurance company.

Enrollment

- The applicant must notify their employer of COBRA election within 60 days of the date on their COBRA notification letter or the termination date (whichever is later). Payment for all health insurance premiums due must be made within 45 days from date of applicant's election to continue coverage.

❖ Direct Purchase Insurance

Insurance purchased directly through the insurance company (DPI) is the preferred method of insurance enrollment for clients.

Eligibility

- Client is not eligible for a group plan through their employer or as a dependent on a spouse's or parent's plan.
- If the client is eligible for other health insurance coverage, that coverage is unaffordable and/or insufficient and does not meet the minimum standards set by the Program.

Enrollment

- Clients may enroll in a DPI plan during open-enrollment or during a special enrollment period.
- Clients must agree to repay any funds owed to the Program as a result of over-payment of premiums or other services.
- Clients must re-certify by their deadline. The Program does not pay premiums for clients who have not re-certified and been approved by the Program by the deadline.
- Confirmation of enrollment in an approved QHP must be received by the Program with sufficient time to process payment prior to payment deadline for insurance coverage.
- Changes in health insurance availability should be reported to the Program as soon as possible.

Qualifying Life Event

- If an eligible client has a qualifying life event during the calendar year in which they become eligible for enrollment in a QHP, then ADAP-I services will become available and clients are expected to enroll in a QHP.

❖ Employer-based Health Insurance Premium Payment (EB-HIPP)

Clients enrolled in a health insurance plan through their employer are eligible for premium payment assistance for the employee's portion of the premium, pharmacy deductible, pharmacy co-payment/co-insurance, and cost-sharing assistance for HIV-related medical care. In cases that employers are unable to separate the client's portion of the premium from a family plan, ADAP-I will cover the entire employee's portion for the family policy. Premiums are paid to the employer or their designee directly and the employee is then reimbursed by the employer for their portion. No cash payments may be made to a client directly.

The Program can help pay for:

- health insurance premiums
- pharmacy deductible
- pharmacy co-payments
- cost-sharing assistance

Eligibility

- Client is eligible, enrolled, and the primary policy holder in their employer-based health insurance plan.

Enrollment

- Clients must agree to repay any funds owed to the Program as a result of over-payment of premiums or other services.
- Clients must re-certify by their deadline. The Program does not pay premiums for clients who have not re-certified and been approved by the Program by the deadline.
- Confirmation of enrollment in an employer-based plan that the client is the primary policy holder.
- Submission of a complete EB-HIPP application completed by the employer must be received by the Program with sufficient time to process payment prior to payment deadline for insurance coverage.

- Changes in health insurance availability should be reported to the Program as soon as possible.

❖ Health Insurance Marketplace

Private insurance purchased through the healthcare.gov Marketplace website. This is the non-preferred method of insurance enrollment for clients.

Eligibility

- Not eligible for group plan through their employer or as a dependent on a spouse's or parent's plan.
- If eligible for other health insurance coverage, that coverage is insufficient and does not meet the minimum standards set by the Program.
- Have household incomes between 100%-400% of the Federal Poverty Level (FPL). Income determination for cost-sharing and subsidies through the Marketplace is determined by the federal government and is different than the income eligibility for the Program.

Enrollment

- Eligible clients will only be able to enroll in a QHP during the open-enrollment period or within 60 days after a qualifying life-event, as determined by the Marketplace.
- Clients must re-certify by the deadline. The Program does not pay premiums for clients who have no re-certified by the re-certification deadline and been approved by the Program.
- Confirmation of enrollment in an approved QHP must be received by the Program with sufficient time to process payment prior to payment deadline for insurance coverage.
- Any change in client income or status should be reported to the Marketplace and the Program within 30 days of the change as eligibility and/or premium amounts may have changed.

Tax Credits

- Clients who are eligible for Advanced Premium Tax Credits (APTC) are required to apply the APTC up-front to lower the cost of their monthly premiums.

- Clients who receive assistance from ADAP-I for insurance through the Marketplace should file a federal income tax return. This tax return should be provided to the Program.
- If tax credits are owed to the Program as a result of under-estimating client income on the Marketplace application, the tax refund amount will be owed to the Program.

Qualifying Life Event

- If an eligible client has a qualifying life event during the calendar year in which they become eligible for enrollment in a QHP, then ADAP-I services will become available and clients are expected to enroll in a QHP.

❖ Medicare Part D

- Clients enrolled in any Medicare Part D plan are eligible to receive assistance from the Program for Medicare Part D premiums, pharmacy deductible, and pharmacy co-payments. Program assistance is limited to Medicare Part D and Medicare pharmacy benefit plans.

❖ Coverage as a Dependent

- Clients covered by a parent or spouse's QHP or COBRA plan are eligible to receive assistance from the Program for pharmacy deductible, co-payments, cost-sharing and the client's portion of the premium only.
- Clients covered by a parent or spouse's Group Plan are eligible to receive assistance from the Program for pharmacy deductible, co-payments, and cost-sharing assistance. Monthly premium assistance is not available.

❖ Group Plan (Employer)

Clients who are employed are expected to pursue insurance enrollment available to them. Similarly, if employer group plan is available through a spouse or a parent, clients should pursue enrollment.

The Program is not able to cover monthly premiums for a group plan when the client is not the primary policy holder. The Program can help pay for:

- Employee portion of the policy premium
- Pharmacy deductible

- Pharmacy copayments
- Cost Sharing Assistance

Eligibility

- Client is eligible for a group plan through their employer or as a dependent on a spouse's or parent's plan.

Enrollment

- Clients may enroll in group plan generally when they are initially hired, during their employer's annual open enrollment or during a special enrollment period.
- Changes in health insurance availability, including loss of group plan coverage, should be reported to the Program as soon as possible.

Stipends and Waiver Benefits

- The Program is the payer of last resort. If an applicant is receiving funds from their employer that is a result of their insurance coverage status, such as a waiver benefit for not enrolling in employer-offered insurance or a stipend to purchase health insurance coverage, those funds must be applied to the cost of premiums, pharmacy deductible and pharmacy co-payments and cost-sharing first before the Program assists with the remaining balance. The amount paid to the applicant by the employer will be included in the applicant's reported income for eligibility determination.

Health Savings Accounts

Employer contributions to a Health Savings Account are counted towards household income.

Insufficient Coverage

In the event that an individual is eligible for group plan coverage but is requesting to enroll in DPI, at least one of the following criteria must be met for the Program to consider covering the client's premiums, pharmacy deductible, pharmacy co-payments, and cost-sharing:

- Health insurance is unaffordable in accordance with ACA and Program standards
- Plan requires the use of a pharmacy that does not accept third-party payments
- Plan excludes access to an HIV provider(s)
- Plan requires prior-authorization for HIV medications
- Privacy concerns regarding a shared plan with spouse or parent

- Plan excludes access to HIV or speciality medications

An Exception Request with the required documentation should be submitted by the Case Management agency for review and approval by Program staff.

Unaffordable Coverage

Clients who have access to a group plan are not required to enroll if the insurance is unaffordable according to the ACA guidelines.

The ACA Guidelines establish that insurance is considered unaffordable if it costs more than a certain percentage of the gross household income. The specific percentage is released annually. To determine unaffordability of premiums, the following guidelines are followed:

- The premiums for the least expensive plan are used to calculate the cost to the client. The client can enroll in a more expensive plan if they choose, but the least expensive plan is used to determine whether or not it is affordable.
- If the least expensive plan meets the insufficient coverage criteria outlined above, then the premiums of the next least expensive plan would be used to calculate the cost to the client.
- Only the portion of the premium paid by the client is considered, not the portion paid by the employer.
- If the client has access to employer insurance through another (i.e. spouse/parent), then the combined premium cost for the employee and the client are considered. The combined premium amount is considered because in order for the client to obtain coverage the policy holder (i.e., spouse/parent) is required to enroll in insurance and pay their portion of the premium in addition to the client's portion of the premium.

An Exception Request with the required documentation should be submitted by the Case Management agency for review and approval by Program staff.

Exemption from Insurance Coverage

- Extensive vigorous pursuit documentation is provided. Refer to the vigorous pursuit policy in this manual
- Available insurance is unaffordable or insufficient
- Client is only eligible for program sponsored DPI plan and deteremined to not be a good candidate for insurance by the benefit specialist or case manager. An explanation must be provided to and approved by the Program.

Vigorous Pursuit of Service Funds

- Vigorous Pursuit of Service Funds Expended for Ineligible Clients
  Clients receiving ADAP-I services for whom health insurance premiums were paid for and who are found to be ineligible during the eligibility period will become ineligible for ADAP-I services the first of the month following the eligibility determination. Clients must cancel their insurance plan and return any unapplied insurance premiums returned by the insurance company to the Program.
- Vigorous Pursuit of Insurance Refunds
  Clients receiving ADAP-I services for whom health insurance premiums were covered by the Program could receive a refund check from the insurance company. The most common reason for client receipt of a refund is policy cancellation due to premium underpayment and the remaining balance being sent to the client. Premium underpayment can occur when client premium amounts change and the Program is not notified. The Program will vigorously pursue any refund a client receives from an insurance company.

Medication Acquisition

Insured clients receiving ADAP-I services may not access medications at a University of Utah pharmacy at any time, unless enrolled in Medicaid Copay Assistance. Insured clients may contact the Program or their case manager for assistance choosing a pharmacy location. The Apothecary Shoppe and Community, A Walgreens Speciality Pharmacy are the Program's preferred pharmacies.

The Apothecary Shoppe
82 South 1100 East Suite #104
Salt Lake City, UT
801-521-6353

Community, A Walgreens Speciality Pharmacy
201 1300 E
Salt Lake City, UT
801-736-9309

Mail-order medication services are intended to reduce barriers to accessing medications and promote treatment adherence to HIV treatment. The Program may cover postage for mail-order medications on the ADAP-I formulary. All ADAP-I clients are eligible for mail-order medications and should work with their provider or case manager to access this service through the Apothecary Shoppe.

The Program does not authorize the mailing of medications to an out-of-state address, even in the case of extended absence out of state, or to individuals who do not reside in the State of Utah.

During a client's eligibility period, ADAP-I will provide co-payment assistance for one 30-day supply at a time of the client's prescribed medication(s) included on the Utah ADAP-I Formulary. Exceptions to the 30-day supply limit may be made once approved by the primary payer source for the following circumstances. Please allow at least one business day to process request:

- Moving – an enrolled client may be eligible to receive one additional 30-day supply of medication(s) if they are moving outside of Utah and services may be interrupted. The client must fill medications while currently residing in Utah and prior to moving out of state. Medications are not provided to those already living outside of Utah or using a mailing address outside of the state. Clients should provide notice to the Program at least five (5) business days prior to the move; a same-day request for expedited approval to accommodate moving plans may not be sufficient time for approval.
- Vacation- an enrolled client may be eligible to receive one additional 30-day supply of medication(s) if they have a scheduled vacation in which medications may run out. Clients should provide notice to the Program at least five (5) business days prior to the vacation; a same-day request for expedited approval to accommodate vacation plans may not be sufficient time for approval.
- A 90 day fill will only be allowed if a 90-day fill is required by the client's insurance and the medication is on the current ADAP-I formulary. 90-day fills will not be allowed for clients on ADAP-M or for medications not listed on the formulary.

If an enrolled client has not filled a prescription(s) within 90 continuous days, services may be suspended due to non-utilization of services. A physician's note or treatment plan may be required in order for the Program to re-activate services for non-adherent clients.

The Program will not replace lost or stolen medications.

Termination

Clients will be terminated from ADAP-I services if they become eligible for drug therapy coverage or insurance under another program or payer source.

Clients may be terminated from ADAP-I services if any of the following occur:

- The client becomes ineligible for the Program, moving out of state, not re-certifying, or not following terms of the Program;
- The client intentionally withholds information regarding availability of other insurance coverage;
- The client elects or is found to be no longer taking HIV antiretovial medications.

Applicants and clients who purposely misrepresent their coverage by health insurance, income, and/or any other eligibility determination information may be terminated temporarily or permanently from the Program, including ADAP-M, ADAP-I, and Support Services. If deemed necessary, the Office of the Attorney General may initiate action against such individuals in order to recover costs associated with covering such clients.

Clients who are receiving ADAP-I services and do not re-certify or are found to be ineligible, will have to re-pay the Program for services rendered during the ineligible time period, including but not limited to health insurance premiums, pharmacy deductible, and/or pharmacy co-payments.

Additional Information

It is prohibited for the Program to directly reimburse the client. The Program cannot reimburse payments made by the client to the insurance company for ADAP-I covered expenses such as pharmacy or medical services.

Clients are expected to accept any other coverage that becomes available through employment or otherwise and must notify the Program of any coverage changes. The client must not knowingly drop any insurance coverage and then apply for ADAP-M services. The Program will only pay eligible clients' pharmacy deductible and pharmacy co-payments for medications on the Utah ADAP-I Formulary. Medications not included on the Formulary will not be covered.

Co-payment assistance cards issued by pharmaceutical manufacturers or other organizations cannot be utilized when an individual is receiving government assistance. Therefore, clients receiving ADAP-I services cannot use co-payment assistance cards. The Program recommends that such co-payment assistance cards be distributed to and utilized by individuals ineligible for the Program.

COST SHARING ASSISTANCE (CSA)

Updated: April, 2021

COST SHARING ASSISTANCE

Cost Sharing Assistance (CSA) is the provision of financial assistance for eligible individuals living with HIV to receive medical benefits under a health insurance program.

Cost-Sharing refers to an insured client's deductible, co-insurance, and co-payments for HIV-related services.

Covered Services

Eligible costs include:

- medical deductibles
- coinsurance and copayments for HIV-related medical care

Non-Covered Services

- HRSA PCN # 13-04 prohibits paying for services that the client receives from a provider that does not belong to the client's health plan's network, unless the client is receiving services that could not have been obtained from an in-network provider.
- Any non-HIV related service.

Eligibility

Insured clients receiving services through ADAP-I and insured clients receiving services through ADAP-M whose coverage has been determined by the Program as insufficient. Clients requesting CSA should work with their case management agency to submit medical bills and necessary documentation.

Limitations

CSA is limited to the client's responsibility of payment and only for the covered services accessed on a date of service when the client is eligible for ADAP-I. Late fees may not be paid by the Program.

OUTPATIENT / AMBULATORY HEALTH SERVICES
Updated: September, 2022

OUTPATIENT/AMBULATORY HEALTH SERVICES

Outpatient/Ambulatory Health Services includes the provision of professional diagnostic and therapeutic services directly to a client by a physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional to prescribe ARV therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight, using telehealth technology, and urgent care facilities for HIV-related visis Emergency room or urgent care services are not considered outpatient settings.
(HRSA PCN #16-02)

Covered Services

- Medical history taking
- Physical Examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavior health conditions
- Behavior risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric development assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Non-Covered Services

- Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory health services category.
- Emergency room visits are not allowable costs within the Outpatient/Ambulatory health services category.

Eligibility and Enrollment

Clients qualify and are enrolled in Outpatient Ambulatory Health Services when they are enrolled in ADAP-M.

Limitations

Services are limited to contracted providers.

MEDICAL CASE MANAGEMENT
Updated: September, 2022

MEDICAL CASE MANAGEMENT

Medical case management services increase access to and retention in medical care.

HRSA/HAB defines medical case management as a range of client-centered services that link clients with health care, psychosocial support, and other services. Coordination and follow-up of medical treatments are components of medical case management. Services ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of clients' and key family members' needs and personal support systems. Medical case management includes treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS regimens. (HRSA PCN #16-02)

Medical case management services are provided by agencies contracted with the Program. Contractors ensure that providers adhere to the current Program Service Standards.

Covered Services

Medical Case Management services include:

- Performing a comprehensive assessment and evaluation;
- Developing, implementing, and evaluating individualized service plans; providing information and recommendations regarding access to Program services, alternative funding sources, and all other services that assist the client to access appropriate; and timely referrals;
- Client monitoring to assess the efficacy of the individualized service plan including re-evaluation and revision of the plan every six months;
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments;
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care;
- Ongoing assessment of the clients's and other key family members' needs and personal support systems;

- Benefit advocacy services will be provided by the client's case manager who: has received training maintains current information regarding Ryan White Programs and services; is knowledgeable about basic eligibility requirements for government benefits and has experience in assisting clients in obtain services such as: housing, government benefits, and health insurance;
- Benefits advocacy services include assistance provided to a client to obtain government benefits, such as Medicaid, Medicare, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), food stamps, utilities, and the continuation of private health insurance;
- The case manager/ case management agency must work in conjunction with a Program Benefits Specialist and the client's primary medical care provider when assisting a client in applying for government benefits where eligibility for the benefit is determined in whole or in part on the client's medical condition; and the Housing Authority when applying for housing; and,
- Client-specific advocacy and/or review of utilization of services;
- Providing assistance and education to clients as needed.

Other Conditions

Minors under the age of 18 accessing Case Management services through the Program must also be enrolled in ADAP or Support Services. Case Management Only services are provided to minors through the Ryan White Part D Program at the University of Utah, Infectious Disease Clinic (IDC).

Medical Case Management providers must work in conjunction with:

- The client's primary care physician;
- The benefits specialists;
- Other Ryan White Part B providers as necessary to assist with the application of benefits;
- The client and their family and/or caregivers; and,
- All other persons or entities included at the client's request as pertinent to the case management care plan.

NON-MEDICAL CASE MANAGEMENT
Updated: September, 2022

NON-MEDICAL CASE MANAGEMENT

As defined by HRSA/HAB, non-medical case management includes advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments. (HRSA PCN #16-02)

Non-medical case management services are provided by agencies contracted with the Program. Contractors ensure that case managers adhere to the current Program Service Standards.

Covered Services

Non-Medical Case Management services include:

- Performing a comprehensive assessment and evaluation;
- Development, implementation and evaluation of an individualized service plan; providing information and recommendations regarding access to Ryan White Part B services, alternative funding sources, and all other services that assist the client access appropriate; and timely referrals;
- Client monitoring to assess the efficacy of the individualized service plan and re-evaluation and revision of the plan as necessary, but at least annually;
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care;
- Ongoing assessment of the clients's and other key family members' needs and personal support systems;
- Benefit advocacy services will be provided by the client's case manager who: has received training and maintains current information regarding Ryan White Programs and services; is knowledgeable about basic eligibility requirements for government benefits and has experience in assisting clients in obtaining services such as: housing, government benefits, and health insurance;
- Benefits advocacy services include assistance provided to a client to obtain government benefits, such as Medicaid, Medicare, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), food stamps, utilities, and the continuation of private health insurance;

- The case manager / case management agency must work in conjunction with the a Program Benefits Specialist and the client's primary medical care provider when assisting a client in applying for government benefits where eligibility for the benefit is determined in whole or in part on the client's medical condition and the Housing Authority when applying for housing; and,
- Client-specific advocacy and/or review of utilization of services;
- Providing assistance and education to clients.

Non-Covered Services

Non-medical case management does not involve coordination and follow-up of medical treatments. Providing hands-on clinical services such as direct nursing care and/or mental health counseling is not covered under non-medical case management services.

Other Conditions

The case management providers must work in conjunction with:

- The client's primary care physician;
- The benefits specialists;
- Other Ryan White Part B providers as necessary to assist with the application of benefits;
- The client and their family and/or caregivers; and,
- All other persons or entities included at the client's request as pertinent to the case management care plan.

MEDICAL TRANSPORTATION SERVICES
Updated: Sept 2022

MEDICAL TRANSPORTATION SERVICES

Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services. (HRSA PCN #16-02)

Covered Services

Covered services include the following:

- Gas Voucher
- Transit Pass
- RideShare
- Other Medical Transportation Services approved by the Program

Non-Covered Services

- Direct cash payments or cash reimbursements to clinets;
- Direct maintenance expenses tires, repairs, etc.) of a privately-owned vehicle;
- Any other costs associated with a privately-owned vehicle such as lease, loan pyaments, insurance, license, or registreation fees.

Eligibility and Enrollment

Medical transportation services are available for clients who are qualify and are enrolled in Support Services or ADAP. Medical transportation ride-share services or vouchers can be obtained through the client's Case Management Agency. Medical Transportation ride-share services or vouchers can be used to transport clients to and from HIV related medical appointments or to access support services. The Program must be the payer of last resort. If other medical transportation services are available to the client those must first be exhausted.

Clients can access transportation services through their case management agency or service provider. Prior to issuing any transportation assistance, service providers should confirm the client is currently eligible for transportation services. If transportation assistance is issued to an ineligible individual, the service provider from which it was

distributed will be responsible for accrued costs; the Program will not cover the cost of transportation services issued to an ineligible individual.

Limitations

- Transportation services are limited to enrolled clients.
- Some transportation services are limited to clients living within a certain area
- Clients may only be reimbursed for certain transportation services through a third party. It is prohibited for the Program to directly reimburse a client.

Providers

Transportation services may be provided by approved vendors as identified by provider agreements with the Program.

EARLY INTERVENTION SERVICES (EIS)
Updated: April, 2020

EARLY INTERVENTION SERVICES (EIS)

The Ryan White Services Program, implements a collaborative Early Intervention Services (EIS) Program that integrates efforts across HIV prevention, Ryan White Part B, and STD-related programs. The EIS service category includes four service areas, all of which must be present for Ryan White HIV/AIDS Program (RWHAP) funds to be used[1], although not all components have to be funded with RWHAP funds. These four areas are outlined below with explanations on implementation.

EIS Services Areas

- Targeted HIV Testing & Counseling
    - This service area is to help those who are unaware of their HIV status become aware of their HIV status and receive either linkage to care, or a referral for prevention services. EIS efforts in this area cannot duplicate or supplant testing efforts that are funded by other sources, and must work in coordination with other HIV testing and prevention efforts.
- Referral Services:
    - This service area is to improve HIV care and treatment services at key points of entry.
- Access and linkage to HIV care and treatment services
    - This service area intends to expedite entry into care, such as HIV Outpatient/Ambulatory Health Services and Medical/Non-Medical Case Management.
- Outreach Services and Health Education/Risk Reduction
    - This service area is designed to reach individuals, both people living with HIV and with unknown HIV-status, and help them become aware of, and familiar

[1] Ryan White Part B Program Manual, February 2015 (https://careacttarget.org/library/part-b-manual)

with, the system of HIV care delivery. The goal of this category is to equip patients/clients with the skills necessary to navigate the system of HIV care.

Eligibility

EIS is a unique service category and provides services to individuals who are not yet enrolled, or otherwise eligible for traditional Ryan White Part B services. EIS is intended to identify new HIV infections by reaching individuals who are at greatest risk for HIV infection and/or being lost to care. Due to these factors, EIS does not follow Ryan White Part B eligibility criteria, unless specified below:

- Eligibility for EIS activities conducted by Disease Intervention Specialists (DIS):
    - Residency
        - All clients must be a Utah resident
            - DIS services are only provided to Utah residents. If a client lives outside of Utah, the case is referred to DIS providing services in the client's resident jurisdiction.
        - Recorded in client's EpiTrax record.
- Eligibility for EIS activities for non-DIS services:
    - Residency
        - Aligns with Ryan White Part B proof of residency guidelines. Refer to the ELIGIBILITY – STATE RESIDENCY section of the Utah Ryan White Part B Program Manual.
            - Homeless individuals or those living in unstable housing may receive an approved letter from their EIS service provider, in lieu of a case management agency.
            - Documentation is stored in the client record with the contracted agency.

Covered Services

Covered services include the following:

- Targeted HIV testing
- Health Education/Risk Reduction activities
- Linkage to care activities
- Outreach activities that lead to a reengagement in care
- Disease intervention activities

EMERGENCY FINANCIAL ASSISTANCE (EFA)
Updated: September, 2022

EMERGENCY FINANCIAL ASSISTANCE (EFA)

The Ryan White HIV/AIDS Treatment and Modernization Act indicates that emergency financial assistance for the provision of short-term housing is a support service . (HRSA PCN #16-02)

Covered Services

Emergency Financial Assistance (EFA) funds are to be used to stabilize clients who are at risk of becoming homeless, since the risk of homelessness affects a client's ability to gain or maintain access to and compliance with HIV-related health services and treatment. Priority will be given to those eligible clients experiencing unstable housing. Assistance may also be provided to those experiencing immediate and/or urgent housing needs (e.g. due to loss of employment).

Eligibility and Enrollment

Clients who qualify for Support Services or ADAP are able to access EFA. Services may be requested with the assistance of a case manager. When applying for EFA, clients must demonstrate that they are unable to obtain assistance from any other source.

The Program is not able to guarantee that payments will be received by the rent or utility payment due date. The Program will not, under any circumstances, pay late fees. It is up to the client to work with their landlord or utility company concerning any late payments. Clients are strongly encouraged to submit their EFA requests at least 7 business days before payment is due. Requests will not be accepted after the last day of the month prior to when rent is due (e.g. application for rent in April will not be accepted after March 31).

Limitations

- If there is more than one adult in the household, the Program will only pay the Part B client's portion of the rent/utilities.
- The Program can only pay for expenses accrued during times that the client is eligible and approved for Part B services.

- Clients may receive up to $3,000.00 or three months of assistance for rent, whichever comes first, in a 12-month period. Clients may not receive more than $6,000.00 in rental assistance in a three year period. Clients may also receive up to $500.00 or three months of assistance for utilities, whichever comes first, in a 12-month period. Clients may not receive more than $1,000.00 of utility assistance in a three year period.
- EFA cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments. Assistance may include rent and basic utilities. The Program cannot pay late fees.

Oral Health Care Services
Updated: September, 2022

ORAL HEALTH CARE SERVICES

Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. (HRSA PCN #16-02)

Covered Services

The Oral Health Services are provided through contracted partners. The majority of diagnostic, preventive, basic, and major services are covered through the Delta Dental at a maximum amount set by the The Program per person each plan year (the amount may vary depending on the funding each year).

Eligibility and Enrollment

Clients who qualify for Support Services and ADAP are able to access oral health services. Clients enrolled in dental services through Medicaid may qualify for oral health service on a case by case staffing by the Program). Those who have denied employer coverage are not eligible for Oral Health Services. A client should work with their case manager to enroll in Oral Health Care services.Limitations

Orthodontics are not covered by Oral Health Care services. Clients are responsible for any services provided that are not covered by the Dental plan, except where prior authorization is received from the program.

FOOD BANK/HOME DELIVERED MEALS
Updated: September, 2022

FOOD BANK/HOME DELIVERED MEALS

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following: personal hygiene products, household cleaning supplies, water filtration/purification systems in communities where issues of water safety exist. (HRSA PCN #16-02)

Covered Services

All foods, personal hygiene products, and household cleaning supplies are covered and can be purchased with food vouchers; however, the purchase of alcohol and tobacco products is prohibited.

Non-Covered Services

- Unallowable costs include household appliances, pet food, and other non-essential productsEligibility and Enrollment
- Clients who qualify for Support Services or ADAP qualify for food vouchers. A client should work with their case manager to request food vouchers.

Limitations

No cash back will be given when the food vouchers are used. Lost or stolen food vouchers will not be replaced / reissued.

Appendix A
EMPLOYMENT VERIFICATION FORM
Updated: September 2022

DOH Form VOE
Effective 7/1/19

Verification of Employment and Health Insurance Availability

Utah Department of Health & Human Services

Instructions: The Utah Department of Health and Human Services is assisting this individual with access to care. This form is used to confirm income, access to health insurance, and/or termination of employment. In order to fulfill the requirement, please complete *all* areas in the following section(s): ☐ **Section 1.** ☐ **Section 2.** ☐ **Section 3.**

To be completed by Employer/Supervisor/Authorized Staff ONLY

Employed Individual: _____

Employer Information:

Company Name: _____ **Email:** _____

Name of Contact Person: _____ **Phone Number:** _____

Street Address: _____ **City:** _____ **Zip Code:** _____

Section 1: Employment Verification:

1. I certify that the above-named individual is a (check one):
2. ☐ Current employee **Or** ☐ Temporary/Seasonal employee
   Date employment began _____ *If Temporary/Seasonal, what is the expected end date?* _____
3. Wage: Hourly $_____/Hour **Or** Salary $_____/Yearly **Or** Other: $_____/Frequency_____
4. Number of hours worked each week: _____
5. Will the number of hours worked each week vary? ☐ No ☐ Yes
   If yes, what are the Minimum hours: _____ **and** *Maximum hours:* _____
   If yes, do the number of hours vary by the season(s)? ☐ No ☐ Yes
   If yes, describe: _____
6. Is overtime offered on a regular basis? ☐ No ☐ Yes *Weekly overtime hours:* _____ *Overtime Rate:* $_____
7. Does employment include Tips? ☐ No ☐ Yes
   If yes, estimated average tip amount (or range): $_____ /week/month/other: _____

Section 2: Health Insurance Verification:

Does employer offer Health Insurance? ☐ No ☐ Yes
If yes, is the employee currently eligible to enroll in employer sponsored Health Insurance? ☐ No ☐ Yes
If yes, is the employee currently enrolled in Health Insurance? ☐ No ☐ Yes
If yes, complete the information below and provide a copy of current year Health Insurance Plan Details

Health Insurance Plan	Enrollment Date	Effective Date	Benefit Plan Year Start Month/End Month	Employer Contribution to Health Savings Account
				☐ No ☐ Yes $_____ Monthly/Yearly/Other _____

If no, *will the employee be eligible to enroll in employer sponsored Health Insurance at a future date?* ☐ No ☐ Yes
If Yes, what is the Enrollment Date _____ **and** *Effective Date* _____

Section 3: Termination of Employment:

Is the above named individual a terminated employee? ☐ No ☐ Yes
If yes, Last Date Worked: _____ **and** Last Paycheck Date: _____
Was the terminated employee enrolled in an insurance plan? ☐No ☐ Yes
If yes, what was the *first* day of insurance coverage? _____
If yes, what is/was the *last* day of insurance coverage? _____
Is there an option for continued medical insurance (COBRA)? ☐ No ☐ Yes, *enrollment deadline* _____

Signature: _____ **Title:** _____ **Date:** _____

This form can be returned to the employee listed above or to the Utah Department of Health and Human Services
Mail: Box 142104, SLC, UT 84114 Fax: 801-536-0978

Appendix B
RESIDENCY VERIFICATION FORM
Updated: April, 2019

Residency Verification Form

To whom this may concern:

I verify that _____ is a resident of the state of Utah and is currently residing at _____.

The above location is categorized as one of the following types (check one applicable box):

- ☐ Place not meant for human habitation (e.g., vehicle, abandoned building, bus or train station, airport, or anywhere outside)
- ☐ Emergency Shelter (including hotel or motel paid for with an emergency shelter voucher)
- ☐ Transitional Housing (e.g. halfway house, sober living, etc.)
- ☐ Hospital, residential medical facility, psychiatric hospital, or other psychiatric facility
- ☐ Jail, prison, or juvenile detention facility
- ☐ Substance use disorder treatment facility or detox center
- ☐ A house or home from which client is currently fleeing to escape domestic or intimate partner violence (IPV)
- ☐ Unstable or Temporary Housing (e.g. couch surfing)
- ☐ Other (please specify in each of the following boxes why the client cannot provide any of the following documentation items below):

Utah Driver's License, Utah State ID, Tribal ID, or Military/Veteran Affairs ID	
Paystubs or Earning Statement	
Financial Institution Document (i.e. Bank statement, credit card statement, etc.)	
Rental or Lease Agreement Mortgage Statement or Property Tax Document	
Utility Bill	
Document issued by the State of Utah (Public assistance, tax document, vehicle title registration, etc.)	
Document issued by US Federal Government or Social Security Award Letter	

I certify that the above information is accurate and that this individual without traditional proof of residency documentation is a qualified Utah resident.

Staff Member Name: _____ **Title:** _____

Staff Phone Number: _____ **Email:** _____

Staff Member Signature: _____ **Date:** _____

V. 5.1.22

Appendix C
CLIENT RIGHTS AND RESPONSIBILITIES
Updated: April, 2019

CLIENT RIGHTS AND RESPONSIBILITIES

Clients accessing <u>any</u> Utah Ryan White Part B Program (Program) service:

<u>As a client of the Program, you have the right</u>:

To be treated with respect, dignity, consideration, and compassion.

To receive services free of discrimination on the basis of race, color, ethnicity, national origin, sex, gender identity, sexual orientation, religion, age, class, physical or mental ability.

To receive information in terms and language that you can understand, and is culturally appropriate.

To reach an agreement with your case manager to set an intake assessment and identify the frequency of contact you will have, either in person or over the phone.

To withdraw your voluntary consent to participate in Case Management services without affecting your medical care or other services for which you are enrolled.

To be informed about services and options available to you, including the cost.

To the assurance of confidentiality of all personal information, communication and records.

To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

To file a grievance about services you are receiving or denial of services according to the Case Management Agency's grievance policy.

<u>As a client of the Program, you have the responsibility:</u>

- To treat other clients, volunteers, and staff with respect and courtesy.
- To protect the confidentiality of other clients you encounter.
- To be free of alcohol or mind altering drugs while receiving Program services or when on the phone with a service provider.
- To let your case manager, know any concerns you have about your case management service plan or changes in your needs.

- To make and keep eligibility and case management appointments.
- To respond to Program communications (calls, letters, etc.).
- To refrain from causing physical, sexual, verbal, or emotional abuse or threats to clients, staff, or volunteers (including pharmacy staff).
- I understand that I am a current resident of Utah and all statements regarding my housing status are true.

Client Responsibilities for ADAP Services (ADAP-I and ADAP-M):

I am applying for Utah Ryan White Part B Program services. By initialing at the end of this authorization, I state that I have read this application and understand the conditions for my participation.

The Utah Ryan White Part B Program (Program) is helping to pay for my health insurance premiums, deductibles, co-insurance, co-payments or ADAP-Medication Assistance. I understand that I have the following responsibilities in order to continue receiving this help:

- I understand that I am the policyholder of my insurance plan being paid for by the Program and I have the responsibility of sharing any letters, bills, and communication I receive from the insurance company with my case manager or benefits specialist.
- I understand if I do not re-certify every six months I am considered ineligible for the Program and I am responsible for paying back any Program money spent on my insurance during the time I did not recertify, which may include monthly premiums, deductibles, co-insurance, and/or co-payments.
- I understand that if I receive a refund check from the insurance company that I have the responsibility to return this money to the Program. I understand that if I do not make payment arrangements with the Program I will not be eligible to continue receiving Program services.
- I understand that if I receive a refund on my tax returns due to underpayment of premium tax credits through the Health Insurance Marketplace that I have the responsibility to return this money to the Program. I understand that if I do not make payment arrangements with the Program I will not be eligible to continue receiving Program services.
- I understand that if I do owe the Program any money due to insurance over-payment,

failure to re-certify every six months, due to underpayment of premium tax credits on the Marketplace, or other reasons then I can enter into a payment plan to continue receiving help from the Program.

- The Program will not help you pay any penalties for not being enrolled in health insurance. You will have to pay any penalties yourself. Under the Affordable Care Act (ACA), the federal tax penalty for not having health insurance in 2018 was $695 per person or 2.5% of your yearly household income, whichever was more. Some people may be exempt from penalties (not have to pay). For example, if you do not make enough money to file a tax return, you may be exempt from penalties.
- If you do not have health insurance and are enrolled in ADAP-M, then you will only be able to get medications listed on the ADAP-M Formulary and only be able to see Program-contracted doctors and providers.
- I understand that I have the responsibility to re-certify with the Program every six months or I risk having my services cancelled.
- I understand it is my responsibility to stay in communication with my case manager / benefits specialist by immediately informing them of changes in my health, income, health insurance, residency, address, phone number, marital status, household size, and/or housing / living arrangements and by responding to my case manager's / benefits specialist's communications (calls, letters, etc.) to the best of my ability.
- I understand that I am a current resident of Utah and all statements regarding my housing status are true.

Client Initials: _____ Date: _____ Case Manager/Benefits Specialist Initials: _____ Date: _____

Appendix D
GRIEVANCE POLICY
Updated: September 2022

GRIEVANCE POLICY

Utah Ryan White Part B Program

Grievance Policy Requirements:

1. Include in Utah Ryan White Part B Program Policy and Procedure Manual.
2. Applicants / clients / Contracted Agencies should be given a copy of the Grievance Policy forms when requested.
3. Staff shall discuss the policy with applicants / clients / Contracted Agencies to ensure that applicants / clients understand the procedures.
4. The HEART will keep a file documenting all grievances, responses and outcomes. All documentation will become a part of the applicant's / client's permanent record and will be filed in the applicant's / client's file.

Quality of Service:

Staff members are guided by the Utah Ryan White Part B Program Policy and Procedure Manual. These policies include Federal requirements, State Agreements and Assurances, as well as the guidelines and responsibilities for AIDS Drug Assistance, Health Insurance Assistance, and Support Services. Reviewing these policies and procedures will help applicants / clients understand the regulations which staff members follow when serving eligible clients.

For a list of client rights and responsibilities and/or a copy of the Client Rights and Responsibilities Agreement, please contact the Utah Ryan White Part B Program at (801) 538-6191 or RWP@utah.gov.

Client Confidentiality:

Every effort is made within the Utah Ryan White Part B Program to maintain client confidentiality at all times. All staff members are given, and required to be familiar with, state and federal laws regarding client confidentiality. Reading the confidentiality requirements may help an applicant / client who fears loss of anonymity.

Notification to the Utah Ryan White Part B Program Client:

You are receiving services from the Ryan White Part B Program within the Bureau of Epidemiology at the Utah Department of Health (UDOH). The development and operation of this Program are supported by The Ryan White CARE Act, Part B funding. Part B funds are administered by the UDOH on a state level.

The Utah Ryan White Part B Program service needs are identified and prioritized through the needs assessment process. Based on this assessment, a plan has been developed for the Program to meet the needs of individuals and families affected by HIV/AIDS in Utah.

The Health Resources and Services Administration (HRSA), which is within the U.S. Department of Health and Human Services (HHS), has lead responsibility for the Ryan White Part B Program. Part B funds are received by the Ryan White Part B Program within the Bureau of Epidemiology at the UDOH. The Utah Ryan White Part B Program and the State of Utah must be in compliance with Federal requirements and contract requirements.

Grievance Procedure:

If an applicant / client /Contracted Agencies (grievant) wishes to express a complaint or make a suggestion for the Utah Ryan White Part B Program, the following procedures should be followed as outlined below:

Level 1

1. Ryan White Part B Core and Support Service Grievance; The Utah Ryan White Part B Administrator will address the Level 1 Statement of Grievance applicant / client / Contracted Agency complaints for issues related to Ryan White Part B Core and Support Services

ADAP/Eligibility Greivance: The Utah ADAP Administrator will address the Level 1 Statement of Grievance applicant / client / Contracted Agencies complaints for issues related to ADAP Services and Program Eligibility.

A. The grievant must complete and submit in writing the Level 1 Statement of Grievance Form within five (5) business days of the alleged complaint.
B. Please describe the occurrence in detail. Use dates and names if known.
C. The grievant should retain a copy for their records.
D. Grievance submission:
    a. Email the statement of grievance from to RWP@Utah.gov, or;
    b. Mail the Level 1 Statement of Grievance Form to:

Utah Department of Health and Human Services
Office of Communicable Diseases

(ATTN: Ryan White Part B)
Box 142104
Salt Lake City, UT 84114-2104

E. The grievant will receive a response in writing by the method of submission (email or USPS mail) within ten (10) business days of the Program receiving the grievance.
F. If the grievant is not satisfied with the response, they must file a Level 2 Statement of Grievance within five (5) business days of receiving the response.

Level 2

2. The HEART Program Manager will address the Level 2 Statement ofGrievance.
   A. The Level 2 Statement of Grievance Form must be completed in writing within five (5) business days of receiving their Level 1 response.
      i. A copy of the Level 1 Grievance Statement and Level 1 response must be attached to the Level 2 Statement of Grievance.
   B. The Heart Program Manager shall respond to the grievant's Level 2 complaint in writing by the method of submission (email or USPS mail) within ten (10) business days of receiving the grievance.
   C. The HEART Program Manager and the grievant will attempt to work together in order to resolve the grievance.
   D. If the grievant is not satisfied with the response, they may file the Level 3 Statement of Grievance within a mandatory five (5) business day period.

Level 3

2. The final level of appeal is Level 3. The Director of the Office of Communicable Diseases will address the Level 3 appeal.
   A. The Level 3 Statement of Grievance Form and submission instructions can be obtained from the Level 2 contact person.
      i. The grievant must complete this form in writing within five (5) business days of receiving their response for the Level 2 appeal.
      ii. The grievant must attach copies of the Level 1 and Level 2 Statements of Grievance and their Level 1 and Level 2 responses for the Level 3 appeal.
         a. The grievance will not be accepted if the grievances and responses are not attached to the Level 3 Grievance.
         b. The Level 3 contact person will not accept the request for appeal if the client has failed to work with the Level 2 contact person.
   B. The Office Director shall respond to the grievant's complaint in writing within twenty (20) business days of receiving the grievance.

Level 1, 2 and 3 Statement of Grievance paperwork provided on the following pages.

Utah Department of Health and Human Services
Office of Communicable Diseases
Utah Ryan White Part B Program

LEVEL 1 STATEMENT OF GRIEVANCE

Date Submitted:_____

Grievant Name:_____

Address:_____

Work Phone Number:_____

Home Phone Number:_____

Date of Birth:_____

Statement of Grievance (Specify in detail)

Grievance is related to: Core or Support Services:_____ ADAP or Program Eligibility_____

Date of occurrence: _____ Location of occurrence: _____

Summary: _____
_____
_____
_____
_____
_____
_____
_____
_____

Remedy Sought: _____
_____
_____
(Continue on other side if needed)

(Please include any paperwork that would help in the decision making)

Signature of Grievant:_____Date:_____

Signature of parent/guardian for minor client _____
Date:_____

Utah Department of Health and Health Resources
Office of Communicable Diseases
Utah Ryan White Part B Program

LEVEL 2 STATEMENT OF GRIEVANCE

Date Submitted:_____

Date of Level 1 Response:_____

Grievant Name:_____

Address:_____

Work Phone Number:_____

Home Phone Number:_____

Date of Birth:_____

Statement of Grievance:
"The Level 1 Statement of Grievance" and "Level 1 Response" must be attached.

Summary of why the grievant disagrees with the Level 1 response:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
(Continue on other side if needed)

I request a Level 2 appeal to resolve a grievance, which occurred on_____.
(Date)

The Level 1 response I received on _____ was unacceptable.
(Date)

Signature of Grievant:_____
Date:_____

Signature of parent/guardian for minor client_____Date:_____

Utah Department of Health and Human Services
Office of Commuicable Diseases
Utah Ryan White Part B Program

LEVEL 3 STATEMENT OF GRIEVANCE

Date Submitted:_____

Date of Level 2 Response:_____

Grievant Name:_____

Address:_____

Work Phone Number:_____

Home Phone Number:_____

Date of Birth:_____

Statement of Grievance and Response: "The Level 1" and the "Level 2 Statements of Grievance" and "Level 1" and "Level 2 Responses" must be attached.

Summary of why the grievant disagrees with the Level 1 and Level 2 response:
_____
_____
_____
_____
_____
_____
_____
(Continue on other side if needed)

(Please include any paperwork that would help in the decision making)

I request a Level 3 appeal to resolve a grievance which occurred on_____.
(Date)
The Level 1 response I received on _____ was unacceptable. The Level 2
(Date)
response I received on _____was also unacceptable. I understand that Level 3

(Date)
is my last level of appeal.

Signature of Grievant:_____
Date:_____

Signature of parent/guardian for minor
client_____Date:_____

Utah Department of Health and Human Serivces
Office of Communicable Diseases
Utah Ryan White Part B Program
CLIENT GRIEVANCE INTAKE AND DISPOSITION
(for staff use only)

Name of Grievant:_____

Grievance Level 1
Client Grievance Statement Received Date: _____
Document Received By: _____
(Name)
Given to Level 1 contact person: _____
(Name)

Summary of Level 1 Response: _____
_____

Response: Accepted by client: _____ Rejected by client: _____

Grievance Level 2
Client Grievance Statement Received Date: _____
All Level 1 documents are enclosed, as required. Yes _____ No _____
Document Received By: _____
(Name)

Given to Level 2 contact person: _____
Summary of Level 2 Response: _____
_____
Response: Accepted by client: _____ Rejected by client: ___ _____

Grievance Level 3
Client Grievance Statement Received Date: _____
All Level 1 and Level 2 documents are enclosed, as required. Yes ____ No _____
Document Received By: _____
(Name)

Given to Level 3 contact person: _____
Level 3 Decision: _____

Client Response:

_____
_____
_____
_____
_____