

# Utah Ryan White Part B Program Policy & Procedure Manual



## UTAH DEPARTMENT OF HEALTH

Division of Disease Control & Prevention  
Bureau of Epidemiology  
Prevention, Treatment, & Care Program

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## **Preface**

This manual is intended for agency staff, grantees, case managers, and others interested in the Utah Ryan White Program. The manual is designed to serve as an orientation guide for new staff and a tool to guide grantees and case managers in assisting applicants in applying and maintaining eligibility for Ryan White Program assistance.

This manual incorporates and replaces the following Utah Ryan White Part B Policy Clarification Notices (PCN) effective July 1, 2016:

- PCN 15-01
- PCN 15-02
- PCN 15-03
- PCN 15-04
- PCN 15-05
- PCN 15-06
- PCN 15-07
- PCN 15-08
- PCN 16-01
- PCN 16-02
- PCN 16-03
- PCN 16-04
- PCN 16-05
- PCN 16-06

This manual and all applications and forms referenced within are available on the Utah Department of Health website at <http://health.utah.gov/epi/treatment/> or available upon request by email [RWP@utah.gov](mailto:RWP@utah.gov).

## **GENERAL INFORMATION ON THE RWHAP AND ADAP**

### **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 supportive 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 Program policies and procedures.

For information regarding Part C and D, please contact: Teddy Bryant, Ryan White Part C and D Administrator, Primary CARE Alliance, 30 North 1900 East, Salt Lake City, UT 84132, [\(801\) 585-5507](tel:8015855507), [Teddy.Bryant@hsc.utah.edu](mailto:Teddy.Bryant@hsc.utah.edu).

For information regarding Part F, please contact: Laura Martel, Utah AIDS Education and Training Center, Department of Internal Medicine, Division of Infectious Disease, Room 4B319 SOM, 30 North 1900 East, Salt Lake City, UT 84132, (801) 581-5310, [laura.martel@hsc.utah.edu](mailto:laura.martel@hsc.utah.edu).

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 Ryan White Program.

AIDS Drug Assistance Program (ADAP) is the Program within the Ryan White 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.

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

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

Marketplace refers to the Federally Facilitated Marketplace (FFM) or the Health Insurance Marketplace accessed at [www.healthcare.gov](http://www.healthcare.gov).

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

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

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Utah AIDS Foundation (UAF) is the non-medical case management service provider for the Program.

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

University of Utah, Infectious Disease Clinic (Clinic 1A) is the ambulatory/outpatient and medical case management service provider for the Program.



## **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 (UDOH), Division of Disease Control and Prevention, Bureau of Epidemiology, Prevention, Treatment and Care Services Program. The Program directly administers the Utah AIDS Drug Assistance Program (ADAP), Core Medical Services, Supportive 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 Prevention, Treatment and Care Program Manager oversees the Program. Responsibility of grant administration program planning, evaluation, and quality management activities is coordinated by the HIV Treatment and Care Manager; day to day activities are equally distributed among two positions: (1) the ADAP Administrator and (2) the Ryan White Part B Administrator.

The Client Services Coordinator and two Client Eligibility Specialists manage the day-to-day activities of both ADAP-M and ADAP-I and Supportive Services. Fiscal support is provided by the Finance Support Services Coordinator (SSC) and Finance Support Services Assistant and a Contract Billing Specialist. The Administrative Assistant is responsible for administrative support for the Program.

### **Utah Continuum of Care**

Through the Program, eligible PLHIV are able to access the following services: Core Medical Services, including ADAP-M and ADAP-I, and Supportive Services. Additionally, PLHIV along the Wasatch Front are able to access primary medical care through any infectious disease provider or clinic, the largest provider being the Infectious Disease Clinic (Clinic 1A) at the University of Utah. PLHIV in rural areas who are unable to travel to the Wasatch Front for care may access care at local community and private clinics.

Case management services, which are vital in order for clients to access and remain in care, are provided through Clinic 1A and the Utah AIDS Foundation (UAF). Both providers receive funding from the Program.

## 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 ( $\leq$ ) 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 and Supplemental Discounts**

- **Rebates:** The Medicaid Drug Rebate Program is authorized by section 1927 of the Social Security Act. The Medicaid Drug Rebate Program was designed as a partnership between the Centers for Medicare & Medicaid Services (CMS), State Medicaid agencies and participating pharmaceutical manufacturers that helps to offset the Federal and State costs of most prescription medications dispensed to Medicaid patients. The Rebate Program requires a pharmaceutical manufacturer to enter into a national rebate agreement with the U.S. Department of Health and Human Services (HHS) in exchange for State Medicaid coverage of most of the pharmaceutical manufacturer's medications. Manufacturers are then responsible for paying a rebate on their medications each time they are dispensed to a Medicaid patient. Medicaid programs submit dispense data to pharmaceutical manufacturers and receive rebate payments on a quarterly basis. Pharmaceutical manufacturers provide many different discounts and rebates to their large variety of customers; the Medicaid Rebate Program provides the basis for the rebates which ADAPs receive for paying pharmacy co-payments and deductibles.
- **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 personnel 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:

**1. 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.

**2. 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).

**3. Broad Scope Awareness Activities:**

No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public.

**4. Lobbying Activities:**

Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel.

**5. Direct Cash Payments:**

No use of Ryan White funds to make direct payments of cash to service recipients.

**6. Employment and Employment Readiness Services:**

Prohibition on the use of Ryan White funds to support employment, vocational, or employment-readiness services.

**7. 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.

**8. 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

## Contact Information

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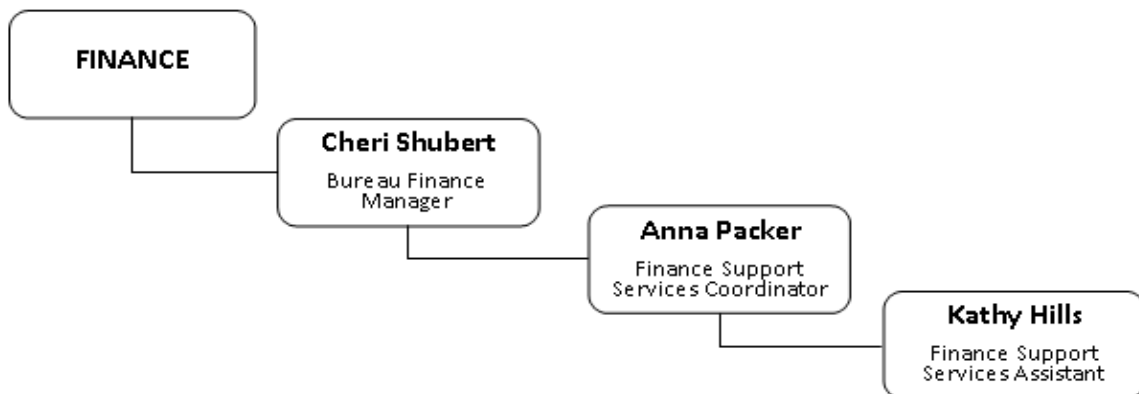
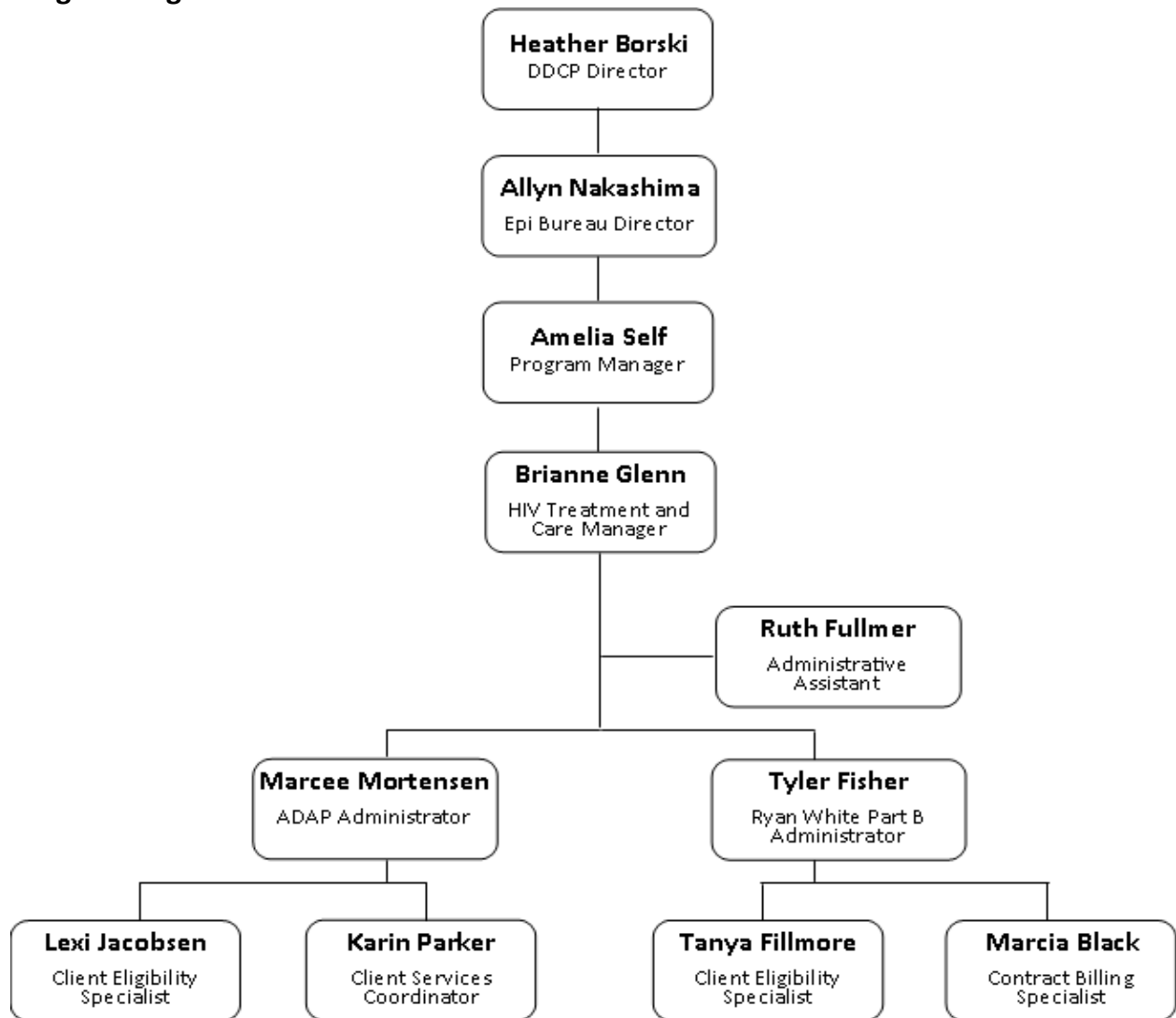
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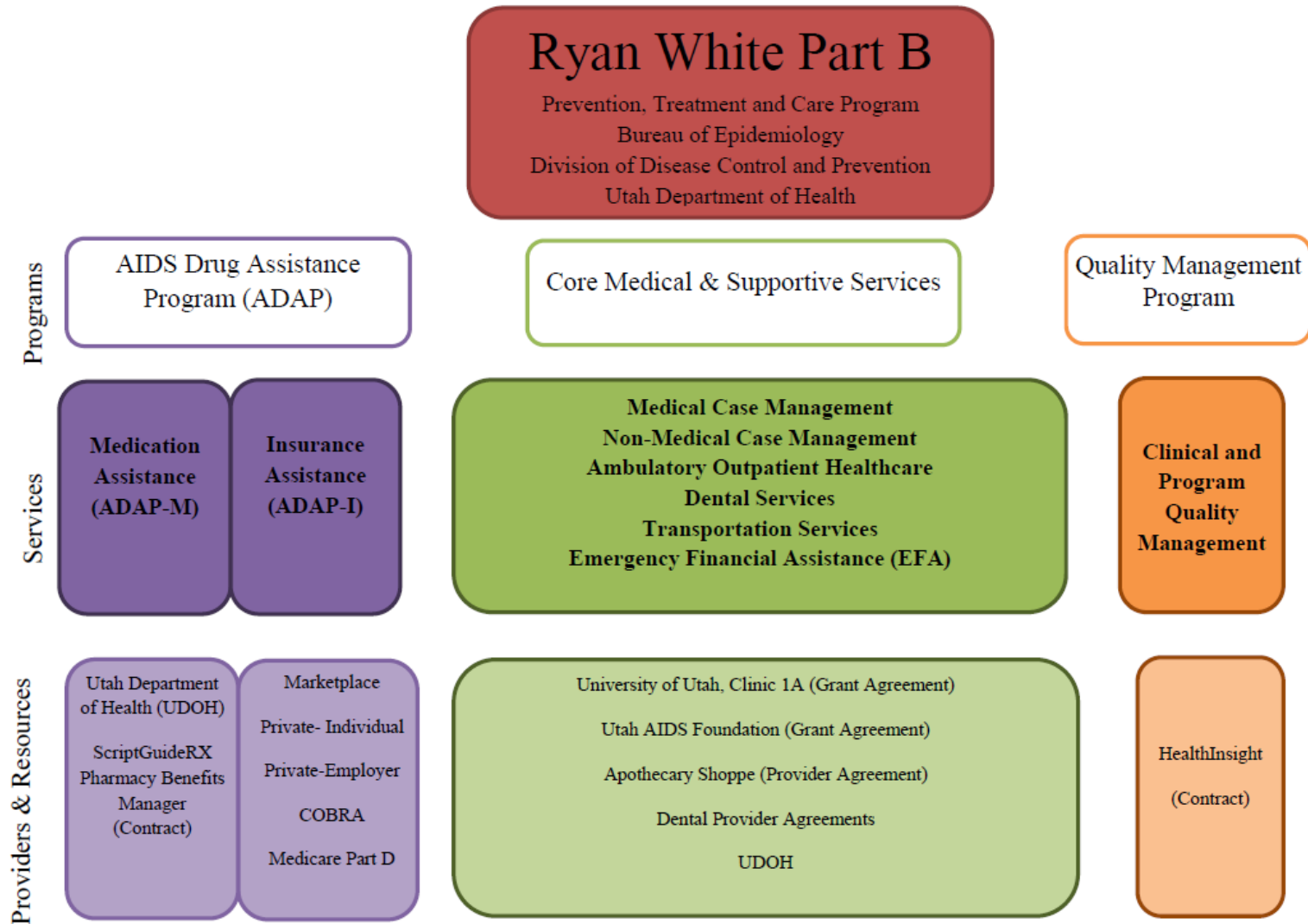
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Program Organizational Chart



Updated January 7, 2017



## ELIGIBILITY

Program eligibility is determined from both individual and household criteria. Recipients must meet **all** of the following eligibility criteria as determined by the Part B Program. The RWHAP legislation mandates that clients receiving treatment services be low-income as defined by the jurisdiction.

### Case Management Only

Clients receiving Case Management Only services must meet all of the following eligibility criteria:

- Each recipient must:
  - Have been diagnosed with HIV/AIDS
  - Reside in Utah

### ADAP, Core Medical, and Supportive Services

Clients receiving ADAP, Core Medical, and/or Supportive Services must meet all of the following individual and household eligibility criteria:

- Each recipient must:
  - Have been diagnosed with HIV/AIDS
  - Reside in Utah
  - Not own more than one registered vehicle, *AND*
  - For ADAP Services:
    - Prescribed HIV Medications such as Antiretroviral Therapy (ARV)
- Each household must:
  - Be at or below 250% of the current year Federal Poverty Level (FPL) according to gross annual household income
  - Not have assets exceeding \$10,000
    - Assets include cash on hand, money in checking and/or savings accounts, income from rental property, or resources that can be quickly converted into cash, such as stocks, bonds, or certificates of deposit.

### Payer of Last Resort

By statute, the Program is the payer of last resort. Individuals must pursue alternative payer sources prior to applying for Program assistance. If an applicant is eligible for Medicaid then they are only eligible for Program services that are not covered or only partially covered by Medicaid ([HRSA PCN # 13-01](#)).

The Program cannot pay Medicaid spend downs. If an applicant is eligible for Medicaid and chooses not to pay their spend down then the Program will not cover those services that would have been covered by Medicaid. Applicants eligible for Medicaid with a required spend down of more than affordable health insurance coverage (9.66% of the household income) may be determined eligible for all Program services as long as Program eligibility criteria are met.



## Eligibility Periods

There are two six-month eligibility periods which are defined by the following dates:

- April 1<sup>st</sup> -September 30<sup>th</sup>
- October 1<sup>st</sup> - March 31<sup>st</sup>

All clients must re-certify every six months for the next eligibility period by the deadline set by the Program to prevent services from being suspended ([HRSA PCN #13-02](#)). Applicants will be eligible from their effective date through the end of the eligibility period for which they are approved. Each client must re-certify for each eligibility period. Clients applying less than 90 days before the new eligibility period may use their most recent application to fulfill the re-certification requirement.

## Eligibility Determination

All forms are available upon request by emailing [RWP@utah.gov](mailto:RWP@utah.gov) or available on our website at <http://health.utah.gov/epi/treatment/>.

The Program will only review and evaluate complete applications and supporting documentation to ensure the eligibility criteria are met. Only Program staff may approve an application.

- Application Date is the date a complete application is received by the Program.
- Approval Date is the date eligibility determination is conducted and results in an approved status.
- Effective Date is the date the client is eligible to begin receiving Part B services. In most instances this will be the application date or may be the client signature date on the appropriate form for Case Management services. For re-certifying clients, this is often the first day of the new eligibility period.

### Approved Applications

Clients who submit a complete application that is approved by the Program will be considered eligible for Part B services effective as of their application date. Clients applying for Case Management will be considered effective as of the client signature date on a complete application

### Denied Applications

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

If an applicant believes an error was made in determining eligibility, the client may appeal the determination decision by submitting an [Exception Request](#) in writing through their case manager 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.

### Incomplete Applications

Eligibility determination cannot be conducted for incomplete applications. Incomplete applications will not be reviewed by the Program; the case manager will be notified it was incomplete. Denial notifications will not be issued by the Program for incomplete applications nor may Program services be provided.

### **Presumptive Eligibility and Retroactive Eligibility**

Presumptive eligibility based on an incomplete application is prohibited by HRSA and the Program will not provide payment for services provided to a client if eligibility determination has not been made even if the client is presumed to be eligible ([2016 ADAP Manual](#), III.1.E, pg 31).

#### Case Management Services

Eligibility for case management services will be considered effective as of the applicant signature date on the complete Application/Recertification/Self-Attestation Form for an eligible client. The Program recognizes that case management services are essential for a client to prepare and submit a completed application and these services are provided before a complete application may be submitted. Eligibility determination is made by the Program; case management services will not be covered for applicants when eligibility determination results in denial. Providers cannot bill the Program for case management services occurring on or after the applicant signature date until the Program has approved the associated Application/Recertification Form.

#### ADAP, Core Medical, and Supportive Services

Eligibility for ADAP, Core Medical, and Supportive Services will be considered effective as of the application date through the end of the eligibility period once eligibility determination results in approval. 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. Providers cannot bill the Program for any service provided during eligibility determination until a client has been approved. Any service provided during eligibility determination to a client who is not approved for the Program will not be covered by the Program.

#### Retroactive Medicaid

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

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. All 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 copays, 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. ADAP-I services will terminate on the first day of the month following the Medicaid determination date. The Program will pursue all unapplied premium payment refunds upon termination of the health insurance plan. The Program may provide Medicaid copay assistance.

#### 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. The Program encourages clients eligible for COBRA to enroll in a QHP during their special enrollment period rather than elect COBRA coverage.

## APPLICATION REQUIREMENTS

All forms are available upon request by emailing [RWP@utah.gov](mailto:RWP@utah.gov) or available on our website at <http://health.utah.gov/epi/treatment/>.

### New Applicants

*Q: When is a new application needed?*

A: When an applicant has never received services from the Utah Program .

All clients are required to meet the eligibility criteria. New applicants are required to complete and submit an application for eligibility determination. Applicants are encouraged to utilize a Program case manager for assistance when completing and submitting the required paperwork. The Program will not review incomplete applications; they will be routed back to the case manager. New applications will be reviewed and eligibility determined by Program staff.

### Case Management Only

- Required documentation to be submitted with a complete application for new applicants for Case Management Services only:
  - Application Form
  - Proof of Residency

### ADAP, Core Medical, and/or Supportive Services:

- Required documentation to be submitted with a complete application for new applicants for ADAP, Core Medical, and/or Supportive Services:
  - Application Form
  - Proof of Residency
  - Proof of Income

### Re-certification

- Eligibility Period: October 1<sup>st</sup>- March 31<sup>st</sup>
- Deadline for Application Submission: September 30<sup>th</sup>
- Application Period: July 1<sup>st</sup>-September 30<sup>th</sup>

*Q: When is a re-certification application needed?*

A: (1) When a client has previously received services from the Utah Program and is applying for services for the eligibility period October 1<sup>st</sup>-March 31<sup>st</sup>

(2) When a client has previously received services from the Utah Program and is applying for services April 1<sup>st</sup>-September 30<sup>th</sup> and missed the last comprehensive re-certification. Self-attestation is not accepted for a client who has missed the last comprehensive re-certification.

*Q: What is the application period?*

A: The application period is the time that clients are able to submit a re-certification for eligibility determination prior to the re-certification deadline. It is recommended that all clients submit their complete re-certification application at least 30 calendar days prior to the deadline to prevent a gap in services while eligibility is determined. If a new applicant submits an application during this application period, the new application can be used to fulfill the next re-certification.

To maintain eligibility for Program services, clients must be recertified every six months for each eligibility period. At least one of these re-certifications must include collection of supporting documentation similar to that collected at the initial eligibility determination. ([HRSA PCN #13-02](#))

All enrolled clients must complete a comprehensive re-certification to remain eligible for services during the October 1<sup>st</sup>- March 31<sup>st</sup> eligibility period. The deadline to submit a complete re-certification is September 30<sup>th</sup>. Services may not be provided prior to eligibility determination. Clients are strongly encouraged to submit a complete re-certification application at least 30 calendar days prior to the re-certification deadline to prevent a gap or suspension of services during eligibility determination by the Program. Clients who submit their re-certification after the deadline may have a gap in services between the end of the previous eligibility period and the approval date of their re-certification. Once a re-certification is approved, clients are eligible from the effective date of coverage through the end of the eligibility period.

Clients are encouraged to utilize their case manager for assistance when completing and submitting the required paperwork. Incomplete re-certification applications will not be reviewed; they will be routed back to the appropriate case manager. All re-certification applications will be reviewed and eligibility determined by Program staff

#### **Case Management Only**

- Required documentation to be submitted with a complete re-certification application for Case Management Services only:
  - Re-certification Form
  - Proof of Residency

#### **ADAP, Core Medical, and/or Supportive Services:**

- Required documentation to be submitted with a complete re-certification application for ADAP, Core Medical, and/or Supportive Services:
  - Re-certification Form
  - Proof of Residency
  - Proof of Income

Eligibility for case management services will be considered effective as of the applicant signature date on the complete re-certification form for an eligible client. Eligibility determination is made by the Program; case management services will not be covered for applicants when eligibility determination results in denial. Providers cannot bill the Program for case management services occurring on or after the applicant signature date until the Program has approved the re-certification application.

If client information changes at any time the client must submit updated information to the Program immediately. Changes in information include:

- Change in income: gain or loss of employment and/or increase or decrease to income amount
- Change in number of cars and homes owned by client
- Change in health insurance: gain or loss of health insurance coverage or a change in the health insurance premium, copays, or plan
- Change in residency/address
- Change in household size, living arrangement, and/or marital status.

If a client is determined to be ineligible at any point during the eligibility period, Part B services will terminate the first day of the month following the determination. This is intended to allow a client to locate alternative sources of financial assistance to prevent interruptions that would lead to medical harm to the client. Failure to notify the Program of such changes could result in services being suspended.

### **Self-Attestation**

- Eligibility Period: April 1<sup>st</sup>-September 30<sup>th</sup>
- Deadline for Application Submission: March 31<sup>st</sup>
- Application period: January 1<sup>st</sup>-March 31<sup>st</sup>

*Q: When is a self-attestation application allowed for re-certification?*

A: When a client is applying for services for the period April 1<sup>st</sup>-September 30<sup>th</sup>, and had been approved for services during the previous eligibility period (October 1<sup>st</sup>- March 31<sup>st</sup>).

Clients who have previously completed a new application or a comprehensive re-certification for the previous eligibility period can self-attest, or self-report, that there are no changes to the eligibility criteria they reported on their previous application or re-certification. Supporting documentation will only be required if a client reports a change in information since the previous eligibility determination or if the Program determines that additional information is necessary for determining eligibility.

Clients who submit their self-attestation after the deadline may have a gap in services between the end of the previous eligibility period and the effective date of their approved self-attestation. Once a self-attestation is approved, clients are eligible from the effective date of coverage through the end of the eligibility period.

### **Case Management Only**

- Required documentation to be submitted with a complete self-attestation application for Case Management Services only:
  - Self-Attestation Form
  - Proof of Residency - only if change of address since last eligibility determination

### **ADAP, Core Medical, and/or Supportive Services:**

- Required documentation to be submitted with a complete self-attestation application for ADAP, Core Medical, and/or Supportive Services:
  - Self-Attestation Form
  - Proof of Residency - only if change of address since last eligibility determination
  - Proof of Income - only if change since last eligibility determination

### **Exception Requests**

The Program may approve an Exception Request submitted by case managers 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 to enroll in private-individual health insurance when other insurance is available (e.g. employer, spouse, parent)

- Request exception from the vigorous pursuit mandate if the client is not a good fit for health insurance

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 manager and retained with the applicant's file for Program records.

### **Expedited Review**

It is prohibited for the Program to provide services prior to eligibility determination (i.e., approved). 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.

### **Descriptions of Required Documents**

The Program reserves the right to seek clarification or additional documentation from any applicant if the submitted documentation is questioned for any reason.

#### **Application Form**

Required for all new applicants who have never received services from the Utah Program. All required fields must be complete with a signature and date and all supporting documents provided to determine eligibility. HIV diagnosis must be confirmed by a physician indication and signature.

#### **Recertification Form**

Required for the eligibility period October 1<sup>st</sup>- March 31<sup>st</sup> or for clients re-certifying for the eligibility period April 1<sup>st</sup>-September 30<sup>th</sup> if it has been 12 months or more since their last application. All required fields must be complete with a signature and date and all supporting documents provided to determine eligibility.

#### **Self-Attestation Form**

May be submitted for the eligibility period April 1<sup>st</sup>-September 30<sup>th</sup> as long as the applicant had recertified and been approved for the previous eligibility period. All required fields must be complete with a signature and date. If client reports a change, supporting documentation is necessary, such as income verification and/or proof of residency.

#### **Income Verification**

*Not required for Case Management only.*

Applicants are required to provide verification of gross annual household income. "Household" is defined as the client, the client's legal spouse, and the client's financial dependents including children. Household income includes income earned by the client and the client's legal spouse. Married applicants are required to provide verification of spouse income.

Acceptable income verification includes providing a copy of at least one of the following documents which features the applicant name or applicant's spouse name:

- One (1) current paystub or earnings statement
- Unemployment Statement from the Department of Workforce Services (DWS)
- General Assistance Letter from DWS

- Pension Letter
- Documentation of Self-Employment Income, such as, but not limited to, IRS Form Schedule C or E
- Social Security/Disability Income (SSDI) or Supplemental Security Income (SSI) Letter or Bank Statement documenting consistent and consecutive SSDI deposit amounts
  - Clients receiving SSI or SSDI benefits will receive a benefits letter from the Social Security office indicating their monthly benefits. Clients receiving SSI or SSDI benefits may submit any of the following as proof of income dated within 12 months prior to the application date:
    - Benefit Verification Letter
    - Benefits Letter
    - Proof of Income Letter
    - Budget Letter
    - Proof of Award Letter
  - Clients with a benefits letter dated more than 12 months prior to their application date can do the following:
    - Request a new letter online from the Social Security Administration Office
    - Submit the previous year's tax form SSA 1099/1042S *\*May not be available for SSI benefits*
    - Submit recent bank statements that show consistent and consecutive deposits in the amount listed on the previous year's benefits letter.

***Affidavit of Zero Income***

- If a client's household receives none of the listed sources of income on the Application/Re-certification/Self-Attestation Form they may complete the Affidavit of Zero Income section.
  - The applicant's household receives none of the listed sources of income.
  - The spouse of an applicant with no income is not required to submit an Affidavit of Zero Income. The applicant is required to indicate they are married with no spousal income on their form.
  - The applicant and/or household member is recently employed but has not received their first paycheck at the time of application/re-certification they are considered Zero Income at the time of application/re-certification. Any income changes are to be reported to the Program.
- If a client is not employed, but the spouse or other household member does receive income, the client should not complete the Affidavit of Zero Income section on the form. The client should indicate on the form that they are not employed and submit the spouse/household member's income documentation.

***Affidavit of Informal Income***

- If a client is without formal employment, employed on a PRN or as-needed basis, or employed as an independent contractor and does not receive any of the listed income documentation, they may complete the Affidavit of Informal Income section on their form and indicate their monthly earnings and source of their earnings.
  - Example A
    - Some employers, such as Uber and Lyft, hire employees as independent contractors and provide pay statements of weekly earnings. These pay statements are not pay stubs and do not reflect

consistent earnings that can be utilized to calculate gross annual household income. Clients who are employed as independent contractors may submit an Affidavit of Informal Income, indicate their monthly earnings and the source of those earnings.

- Example B
  - A client may be unemployed but work odd jobs as a handyman, day laborer, performing artist, etc., and receive cash earnings. This client may not have paystubs or earnings statements but may have monthly earnings. Clients may submit an Affidavit of Informal Income, indicate their monthly earnings, and the source of those earnings.

### **Proof of Residency**

All applicants are required to maintain Utah residency in order to be eligible for Ryan White Part B services in Utah. Proof of Residency documentation is not required to match client's mailing address. PO Boxes are not acceptable as Proof of Residency. All applicants must provide a copy of at least one of the following documents which features the applicant name and Utah street address as proof of Utah residency:

- Utah ID
- Utah Driver License
- Paystub/Earnings Statement
- Bank Statement
- Bill
- Official Medical Documentation
- Document issued by the State of Utah
- Document issued by the United States Federal Government
- Rent Agreement/Mortgage Agreement
- Federal IRS Tax Transcript
- Homeless Shelter Voucher
- Statement of Support



## SERVICE PROVIDER GUIDELINES AND RESPONSIBILITIES

Providers are expected to:

- Verify applicant enrollment status and eligibility. Each week the Program provides the case manager supervisors at Clinic 1A and the UAF with a list of currently enrolled clients. Please refer to the most recent list to verify enrollment status and eligibility for services. Questions regarding enrollment status and eligibility can be directed to the Program by calling (801) 538-6191 OR via email [RWP@utah.gov](mailto:RWP@utah.gov).
- Assist applicants in applying and clients in 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).
- 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 Part B enrolled clients only.
- Participate in an annual monitoring visit.
- 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.).

## CLIENT RIGHTS AND RESPONSIBILITIES

### ADAP-I Services

The Utah Ryan White Program (Program) is helping to pay for my health insurance premiums, deductibles, co-insurance, and co-payments through ADAP-I services. 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.
- I understand that I have the responsibility to re-certify with the Program every six months or I risk having my insurance plan cancelled. If I do not re-certify 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.
- I understand that if I do not return any money owed to the Program and do not arrange for payment, I will not continue receiving help from the Program.

### ADAP-M Services

If you do not have health insurance, for any reason, and want to keep getting services from the Program including ADAP- Medication Assistance (ADAP-M), there may be serious consequences.

- Under the Affordable Care Act (ACA), the penalty for not having health insurance in 2016 is \$695.00 per person or 2.5% of your yearly household income, whichever is more. The Program **will not** help you pay this penalty. You will have to pay the penalty yourself. Some people may be exempt from the penalty (not have to pay). For example, if you do not make enough money to file a tax return, you are exempt from the penalty.
- If you do not have health insurance and are enrolled in the Program, then you will only be able to get medications listed on the ADAP-M Formulary and only be able to see Program doctors and providers.
- If the Program does not have enough money to help everyone, there will be people placed on a wait-list. The people who choose to not get health insurance but could have may have their place on the wait-list affected by this choice.

## All Clients

### As a client of the Program, you have the **right**:

- 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 participate in creating a plan for services.
- To reach an agreement with your case manager about 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 benefits to which you are entitled.
- 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 Program Grievance Policy.

### As a client of the Program, you have the **responsibility**:

- 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 participate in creating a service plan and to take an active role in resolving that plan.
- To let your case manager know any concerns you have about your case management plan or changes in your needs.
- To make and keep appointments to the best of your ability, or to phone to cancel or change an appointment time, whenever possible.
- To stay in communication with your case manager by immediately informing her/him of changes in your health, income, assets, health insurance, residency / address, phone number, marital status, household size, and/or living arrangements and by responding to your case manager's calls or letters to the best of your ability.
- To respond to Program calls or letters to the best of your ability.
- To submit a complete re-certification application to the Program every six months.
- To refrain from knowingly falsifying documentation or information related to eligibility.
- To refrain from causing physical, sexual, verbal, or emotional abuse or threats to clients, staff, or volunteers (including pharmacy staff).

## UTAH AIDS DRUG ASSISTANCE PROGRAM (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 seeks to (1) facilitate access to medications that prolong life or prevent the serious deterioration of health, and (2) 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 seeks to (1) assist individuals in maintaining the continuity of medical services established through their health insurance coverage, including HIV and AIDS medication(s), (2) 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 (3) reduce the fiscal impact of HIV and AIDS on publicly-funded programs.

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

### Utah ADAP 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, Medicare Part D, Private-Individual, 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.

### Enrollment

New applications are accepted on a rolling basis. Once approved, a client is eligible for the remainder of the eligibility period. If applying within 90 days of the next eligibility period, the most recent application may be used to apply for the current and following eligibility period. 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.

### ADAP Advisory Subcommittee

The purpose of the Utah ADAP Advisory Subcommittee 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)

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. For uninsured clients needing assistance with medical visits and healthcare costs, assistance is provided through 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 are not eligible for ADAP-M services.

ADAP-M services are best suited for:

- Uninsured or under-insured clients who cannot enroll or decline to enroll in ADAP-I sponsored QHP
- 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:

- **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](mailto: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 manager and retained with the applicant's file for Program records.

**If an enrolled client has not filled a prescription(s) within 90 continuous days, services may be suspended. 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.**

#### 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 **permanently** from the Program, including Core Medical, ADAP-M, ADAP-I, and Supportive 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-HEALTH INSURANCE ASSISTANCE (ADAP-I)**

### Core Medical Service

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.

The Program provides the following health insurance payment assistance:

- Monthly premiums
- Pharmacy deductibles, co-payments and/or co-insurance for medications on the ADAP-I formulary
- Medical deductible, co-payments and/or co-insurance for outpatient/ambulatory 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 eligible clients with private-employer health insurance; only Medicare Part D, and private-individual Qualified Health Plan (QHP) 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.

### **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 may decline insurance coverage and receive medication services through ADAP-M.

### **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 from November to January 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, 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.



### **Premium Payment Assistance**

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

- COBRA
- Coverage as a dependent on a spouse or family non-employer QHP
- Health Insurance Marketplace (Marketplace) QHP
- Direct Purchase 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. Premium payment assistance is not available to clients with health insurance from an employer-offered plan, whether the client is the policy holder or a dependent, due to logistical payment barriers. For example, most employers deduct the premium amount(s) from employee paychecks and the Program is prohibited from paying or reimbursing clients directly. Clients enrolled in a health insurance plan through their employer are eligible for pharmacy deductible, pharmacy co-payment/co-insurance, and cost-sharing assistance for HIV-related medical care.

### **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, and pharmacy co-payments and cost-sharing assistance for clients who are enrolled in a COBRA plan.
- 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. It is preferred to have a client enroll in a QHP during the special enrollment period after losing a job.
- 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.
- 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**

Private-individual insurance purchased directly through the insurance company is the preferred method of insurance enrollment for clients.

- **Eligibility**
  - Client is not eligible for any other health insurance coverage 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 plan during open-enrollment or during a special enrollment period they may qualify for due to a life-changing event or other factors.
  - 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 the deadline. The Program does not pay premiums for clients who have not 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 insurance company and the Program within 30 days of the change as eligibility and/or premium amounts may have changed.
- **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.

### 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 any other health insurance coverage 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 not 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; assistance is not offered for any other Medicare plans or programs.

#### **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' employer-offered plan are eligible to receive assistance from the Program for pharmacy deductible, co-payments, and cost-sharing assistance. Monthly premium assistance is not available.

#### **Employer-Based Insurance**

Clients who are employed are expected to pursue insurance enrollment available to them. Similarly, if employer-based insurance is available through a spouse or a parent, clients should pursue enrollment. The Program is not able to cover monthly premiums for an employer-based insurance plan.

- Private Employer-Based Coverage
  - Clients covered by an employer-offered plan or as a dependent on a spouse or parent's employer-offered plan are eligible to receive assistance from the Program for pharmacy deductible, co-payments, and cost-sharing assistance. Monthly premium assistance is not available.
- 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.

### **Insufficient Coverage**

In the event that an individual is eligible for their employer-offered insurance or coverage on a parent or spouse's health insurance plan, but would prefer to enroll in a private QHP, at least one of the following criteria must be met for the Program to consider covering the client's QHP 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

An [Exception Request](#) with the required documentation should be submitted by the Case Manager for review and approval by Program staff.

### **Unaffordable Coverage**

Clients who have access to employer health insurance are not required to enroll in their employer health insurance if the insurance is unaffordable according to the ACA guidelines.

The ACA Guidelines establish that insurance is considered unaffordable if it costs more than 9.66% of the gross household income. 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 insurance through their own employer, then premiums to cover only the client are considered.
- 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 Manager for review and approval by Program staff.

### **Exemption from Insurance Coverage**

- A Part B client eligible to enroll in an insurance plan but chooses not to enroll may receive services through ADAP-M. This client is considered "declining" insurance.
- Clients should provide a clear explanation for declining to enroll in available insurance on their Application or Re-certification Form.

- Clients should receive information regarding availability of insurance, potential benefits, and consequences of not enrolling (e.g., individual mandate penalty) prior to declining to enroll in insurance available to them.
- The Case Manager may need to submit an Exception Request if client is assessed as not a good fit for insurance.

## **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. Insured clients may contact the Program or their case manager for assistance choosing a pharmacy location. The Apothecary Shoppe is the Program's preferred pharmacy.

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

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.

**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 will be terminated from ADAP-I services if any of the following occur:

- The client becomes eligible for Medicaid;
- The client becomes ineligible for the Program, moving out of state, not re-certifying, or not following terms of the Program;
- The client does not notify the Program regarding any change in health insurance premium amounts resulting in incorrect or otherwise insufficient premium payment being made by the Program to the client's insurance company. The result of insufficient premium payment is termination of health insurance coverage for the client. The client may be eligible for ADAP-M services.

Applicants and clients who purposely misrepresent their coverage by health insurance, income, and/or any other eligibility determination information may be terminated **permanently** from the Program, including ADAP-M, ADAP-I, and Supportive 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. Additionally, 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**

### Core Medical Service

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. Clients requesting CSA should work with their case manager 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**

### Core Medical Service

Ambulatory/Outpatient 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. Emergency room or urgent care services are not considered outpatient settings.

### **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

### **Eligibility**

University of Utah, Clinic 1A provides comprehensive Outpatient/Ambulatory Health Services to uninsured/underinsured clients eligible for ADAP-M services.

The Apothecary Shoppe provides limited Outpatient/Ambulatory Health Services to eligible clients, but does not provide primary medical care.



## **MEDICAL CASE MANAGEMENT**

### Core Medical Service

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 supportive 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.

Medical case management services are provided by agencies contracted with the Program.

Contractors ensure that providers:

- Hold and maintain appropriate licensure to provide medical case management services (i.e., RN, LCSW, and/or CSW/SSW/LPC under the direction of a physician, RN, and/or LCSW as outlined by the Department of Occupational and Professional Licensing) or 2 or more years of experience working as a medical HIV case manager in Utah;
- Have received training, continue to receive training, and maintain current information regarding Ryan White Programs and services
- Have experience in the field of case management and understand the legal, social, and clinical aspects of case management.

Currently, medical case management services are offered through the University of Utah, Clinic 1A.

### **Covered Services**

Medical Case Management services include:

- Performing a comprehensive assessment and evaluation;
- Developing, implementing, and evaluating individualized care 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 care plan including re-evaluation and revision of the plan every six months;
- 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 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,
- Providing assistance and education to clients as needed.

### **Non-Covered Services**

Providing hands-on clinical services such as direct nursing care and/or mental health counseling is not covered under medical case management services.

### **Other Conditions**

Minors under the age of 18 accessing Case Management services through the Program must also be enrolled in ADAP or Supportive Services. Case Management Only services are provided to minors through the Ryan White Part D Program at the University of Utah, Clinic 1A.

The case management providers must work in conjunction with:

- The client's primary care physician;
- 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**

### Supportive Service

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.

Non-medical case management services are provided by agencies contracted with the Program. Contractors ensure that case managers:

- Hold and maintain appropriate licensure to provide case management service (i.e., RN, LCSW, and/or BSW/SSW/LPC under the direction of a physician, RN, and/or LCSW as outlined by the Department of Occupational and Professional Licensing);
- Have received training, continue to receive training, and maintain current information regarding Ryan White Programs and services;
- Have experience in the field of case management and understand the legal and social aspects of case management.

Currently, non-medical case management services are offered through the UAF.

### **Covered Services**

Non-Medical Case Management services include:

- Performing a comprehensive assessment and evaluation;
- Development, implementation and evaluation of an individualized care 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 care plan and re-evaluation and revision of the plan as necessary, but at least annually;
- 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 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,
- 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;
- 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**

### Supportive Service

Medical transportation services are available for eligible clients to access HIV-related health and support services, including services needed to maintain the client in HIV medical care. Medical transportation services are conveyance services provided directly or through a voucher.

### **Providers**

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

### **Covered Services**

Covered services include the following:

- Pre-paid Gas Certificates through Smith's Fuel Centers
- Utah Transit Authority (UTA) All-Day Passes
- Taxicab Vouchers  
Taxicab vouchers are only to be used when the client is too ill to drive or ride UTA.

### **Eligibility**

Only eligible Program clients are able to access transportation services. Clients can access transportation services through their case manager 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 the eligible clients.
- Clients may only be reimbursed through a third party. It is prohibited for the Program to directly reimburse a client.

## **EMERGENCY FINANCIAL ASSISTANCE (EFA)**

### Supportive Service

- I. Food Vouchers
- II. Short-Term Housing and Utilities

### **I. Food Vouchers (Emergency Only)**

The Ryan White HIV/AIDS Treatment and Modernization Act indicates that emergency financial assistance for the provision of food (including groceries, food vouchers, and food stamps) is a supportive service (HRSA [PCN #16-02](#))

#### **Covered Services**

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

#### **Eligibility**

Only eligible Program clients are able to access food vouchers. A client should work with their case manager or primary care provider to request food vouchers.

#### **Limitations**

Emergency food vouchers are limited to one lifetime disbursement of \$60.00 per client. Food vouchers are to be issued only to clients who are in an emergency situation. No cash back will be given when the food certificates are used. Lost or stolen food certificates will not be replaced / reissued. This service will be discontinued when all pre-purchased food certificates have been issued.

## II. Housing and Utilities

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

The Ryan White Program (Program) has limited funding available to provide Emergency Financial Assistance (EFA) to eligible Part B clients to support assistance for housing and utilities. Individuals who are not currently Part B clients may still apply for EFA, but will also need to complete the Ryan White Part B Application Form and be approved for services.

### Covered Services

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).

EFA cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments. Assistance may include: rent, nonrefundable deposits, and utilities. Utilities that are covered include the basic necessary utilities (e.g. water, gas, electric, etc.). Bills that are not considered necessary will not be covered (e.g. phone, internet, cable, etc.)

### Eligibility

Only eligible Program clients are able to access housing and utility assistance. The Program is the payer of last resort. When applying for EFA, clients must demonstrate that they are unable to obtain assistance from any other source.

**EFA is meant to be short-term and must be requested by the case manager.** The following documentation **must** be provided when requesting assistance:

- Rent/Deposit
  - Housing Assistance Request Form
  - Documentation from Landlord, in writing:
    - Amount of rent and/or deposit
    - Amount of any utilities included in rent
    - Payee (vendor) name as it should appear on the check
    - Payment Remittance address
    - Unit and/or address of housing
    - Payment due date (including what happens if payment is due on a holiday or weekend)
    - If deposit assistance is being requested, include written documentation from the Landlord stating that the deposit will neither be refunded to the client nor applied to the last month of rent upon move out.
- Utilities
  - Housing Assistance Request Form
  - Actual bill that itemizes the services and dates of service (statements that show only the lump sum due will not be accepted)

The Program can only pay for expenses accrued during times that the client is eligible and approved for Part B services.

## Limitations

The EFA request will be reviewed for eligibility by Program staff within **3 business days** of receipt, at which time approval or denial will be indicated. If approved, the Program will also indicate the dollar amount approved. 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.

**Due to Utah State Purchasing Policy, the Program can only pay up to \$1,000.00 per landlord, per month.**

The entire process, including remittance of payment, takes approximately **20 business days**. We do not guarantee that payments will be received by the 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 complete Housing Assistance Request Forms at least 20 business days before payment is due. Assistance Requests will not be accepted after the last day of the month prior to when rent is due (e.g., Housing Assistance Request Forms for rent in April will not be accepted after March 31).

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.

Checks that are sent out do not reference HIV/AIDS or the Program; they are labeled from the State of Utah. For confidentiality reasons, the check will not list the client's name. The check will include the account number, if one is available, and the address for which payment is intended. It is up to the client to notify their landlord that they will be receiving a check from the State of Utah.

Please refer EFA questions directly to Karin Parker at 801-538-6197 or [kparker@utah.gov](mailto:kparker@utah.gov).



## **DENTAL SERVICES**

### Core Medical Service

The Dental Program provides diagnostic, preventive, and therapeutic dental care provided by licensed and certified dental professionals. Funding for the Dental Program is not always guaranteed and the Dental Program may close at any time when funding is expended.

### **Covered Services**

Approved services are listed in the Fee Schedule available to contracted Dental Providers. Clients may make their own appointments but should call the Program to verify their eligibility prior to receiving any services. Clients may also work with their case manager to access dental services. There may be a service amount limitation if funding is limited or a client has received dental services before.

### **Eligibility**

Only eligible clients are able to access dental services. Dental Providers are required to verify client eligibility prior to performing any services. Clients should verify their own eligibility prior to receiving any services to prevent accruing any personal costs associated with services received during a time they were not eligible. As Medicaid does not provide dental services, the Program can provide dental services as the payer of last resort to eligible clients enrolled in Medicaid.

### **Limitations**

Only services that are approved on the Program Fee Schedule will be covered for eligible clients. Services may be limited by number or cost of procedures. When funding is expended the Dental Program will close. Requests for payment of dental services that are expected to exceed the service limitation and/or not on the approved Fee Schedule may be submitted for Program review as a prior authorization.

## **TREATMENT ADHERENCE COUNSELING**

### Supportive Service

Treatment Adherence Counseling as defined by the National Monitoring Standards is a supportive service intended to ensure readiness for, and adherence to, complex HIV/AIDS treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting. Treatment Adherence Counseling services for all eligible clients are currently available at the UAF.

### **Covered Services**

Treatment adherence counselors provide the following services:

- Recruit clients into service
- Meet with clients referred by the Program, case managers, physicians, pharmacists, or clients who self-refer for adherence assistance
- Conduct intake process to collect client information and to identify barriers to adherence
- Develop an achievable plan with the client to remove the barriers for long-term adherence
- Provide one or more sessions or follow-up contacts to achieve plan objectives and adherence
- Utilize email, text, or phone call reminders to take medications,
- Monitor client adherence through pharmacy utilization data

### **Eligibility**

All eligible clients are eligible for Treatment Adherence Counseling services through the Non-Medical Case Management organization, UAF.