Here you will find answers to frequently asked questions about the Ryan White Program and the Affordable Care Act. To learn more about Ryan White and the Affordable Care Act, including resources, guidance, and policy notices, check out Ryan White & the Affordable Care Act: What You Need to Know at hab.hrsa.gov/affordablecareact.

1. AIDS Drug Assistance Program (ADAP)

1.1 May Part D funds be used for premium and cost sharing assistance?
Yes. If sufficient resources are available, Part D funds can be used towards payment of insurance co-pays, deductibles, and premium assistance as is outlined in Policy Clarification Notice 13-05. The purpose of the Ryan White HIV/AIDS Program Part D is to provide family-centered care involving outpatient or ambulatory care directly or through contract for women, infants, children, and youth with HIV/AIDS. Part D clinics may elect to use RWHAP grant funds to pay for insurance premiums, co-pays, and deductibles but are cautioned to do so only if services for family-centered care is completely supported. Part D programs are encouraged to have a policy and procedure in place for enrollment in premium and cost sharing assistance to ensure that all persons receiving services are fairly and equitably assessed.

1.2 If a client has access to private or employee-sponsored insurance but elects not to utilize it, may he or she receive services paid for by RWHAP?
By statute, RWHAP funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made…” by another payment source. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services. Grantees and subgrantees must also assure that individual clients are enrolled in health care coverage whenever possible or applicable, and informed about the consequences for not enrolling. Grantees are expected to have a policy and procedure in place in order to uniformly document their efforts to pursue coverage options for clients. See Policy Clarification Notice 13-04 for more information.

1.3 How should AIDS Drug Assistance Program (ADAP) deal with transitioning patients into the new insurance options created under the Affordable Care Act? How can they address key challenges such as increased cost-sharing in the Health Insurance Marketplace as compared to ADAPs?
The HIV/AIDS Bureau expects grantees to acquire knowledge and expertise regarding the Affordable
Care Act and the key components being implemented in their states. Grantees should be familiar with the different Medicaid, Medicare, and private insurance plans available to assist their clients in choosing the best option for their health care coverage needs such as ensuring that medications they will need are available to them at a cost they can afford and an HIV/AIDS provider is included in their plan’s provider network.

ADAP funds may be used to cover costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage. See Policy Clarification Notices 13-05 and 13-06 for additional information. Grantees should inform their clients if ADAP will provide insurance premium assistance and/or copayment and deductible assistance and if there are specific plans that the ADAP will be working with. For patients eligible for coverage through private insurance in the Marketplace, navigators, non-navigator assistance personnel, certified application counselors and insurance brokers can also assist in understanding the different options available, premium tax credits and other mechanisms available to make purchasing insurance affordable.

1.4 Will the State ADAP funding still be available for persons enrolled in a Health Insurance Marketplace or will their medications need to come under the new health insurance coverage options?

Ryan White HIV/AIDS Program (RWHAP) Part B ADAP funds will continue to provide completeness of coverage for needed pharmaceutical services. If a patient has health insurance with pharmacy benefits through the Health Insurance Marketplace or other private insurance, that insurance should pay for medication. ADAP may assist clients with the co-pays and deductibles for medications. If an HIV-related medication is not covered, then RWHAP ADAP may pay. Further, ADAP funds may be used to cover any costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage as outlined in Policy Notices 07-05 and 13-05.

1.5 What will happen to ADAP, now that the Affordable Care Act has been fully implemented?

The HIV/AIDS Bureau expects that all grantees will continue to comply with payer of last resort, and vigorously pursue enrollment of eligible clients. Each State ADAP makes determinations regarding support for health coverage depending on the availability of funds and other program administration factors. Please contact your State ADAP for more information.

1.6 Some states or counties will be offering extra subsidies/incentives to enroll low-income individuals into private insurance. How will these subsidies affect ADAP enrollment and RWHAP participation?

These subsidies/incentives do not affect ADAP enrollment and RWHAP participation. RWHAP legislation requires that RWHAP funds only be used as a payer of last resort and clients eligible for health insurance should be enrolled in private coverage. Clients may still continue to be eligible for ADAP and RWHAP services and receive assistance with premiums, copayments, deductibles and receive RWHAP services that are not covered or are partially covered by other payer sources.
2. Choosing a Health Plan

2.1 Will homeless RWHAP clients have to transition to other providers as a result of Affordable Care Act?
Some clients may be required to transition depending on the health insurance package in which they enroll. If an individual's current RWHAP provider is part of the provider network of the client’s new health insurance plan, then they won’t have to transition. If the provider is not part of the client’s new health insurance network, the client will likely need to transition to a provider covered by the client’s health insurance. Depending on the type of policy you buy, care may be covered only when you get care from a network provider. For example, when comparing plans in the Marketplace, people will see a link to a list of providers (i.e., the Provider Directory) in each plan’s network. People can check there to see if their current provider is included before choosing a plan. Although this issue is not unique to the homeless population, RWHAP grantees and providers should consider the additional complicating factor of homelessness when assisting clients to enroll in health insurance coverage. For more information on keeping your doctor when transitioning to a new plan, visit [https://www.healthcare.gov/can-i-keep-my-own-doctor/](https://www.healthcare.gov/can-i-keep-my-own-doctor/).

2.2 Can insurance providers require the use of mail order pharmacies by homeless clients who do not have an address?
Insurance providers can require the use of mail order pharmacies. Some RWHAP-funded ADAPs that use mail order pharmacies provide the clinic or shelter address for homeless clients, allowing the individual to pick up the medications from these locations in place of a residential mailbox.

2.3 Should clients be advised to stay with their COBRA policies until they expire and then enroll in the Marketplace?
The RWHAP expects grantees to conduct a cost-effectiveness analysis to determine whether an insurance plan may be paid for the RWHAP. Policy Clarification Notice #13-05 states that “The grantee must determine how to operationalize the health insurance premium and cost-sharing assistance program, including the methodology used by the grantee to: (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate primary care services.”

2.4 It is my understanding that since my State will have a federally run Marketplace, the only insurance options will be the 'silver' level plan for anyone with a pre-existing condition like HIV/AIDS. Is this correct?
Clients have the option of selecting and purchasing the insurance plan at any level that suits their needs. The Health Insurance Marketplace insurance group plans are categorized into four levels: Bronze, Silver, Gold, and Platinum, based on cost sharing. All Marketplace insurance plan categories must include essential health benefits, but the Silver Plan will be the benchmark for premium tax credits and cost-sharing reductions. People living with HIV/AIDS (PLWH) will have to weigh their new insurance options...
carefully. They need to consider the availability of appropriate specialists, pharmacy formularies, other insurance options, and the availability of health care and pharmacy assistance, as well as the cost associated with co-pays, premiums, and other cost sharing options. For more information click https://www.healthcare.gov/will-i-qualify-to-save-on-out-of-pocket-costs/.

2.5 For PLWH, especially those who make more than 133 percent of the Federal Poverty Level (FPL), will their decisions be more complex (and require more input) than the insurance information offered through a Health Insurance Marketplace? Should RWHAP providers explain the extra benefits the new insurance coverage options will have over Ryan White (i.e., emergency room and inpatient care)?

Making decisions about health insurance is difficult for everyone. For PLWH, the decision about which insurance to buy in the Marketplace is especially important because their decision must be based on the type of coverage needed for things like prescription drug coverage and expenses the client is able to afford, and if the plan's network includes an HIV/AIDS provider. RWHAP providers should make every effort to educate their clients about the changes the Affordable Care Act brings, to inform clients of coverage options, and to help them make educated decisions about their choice of health plans. The primary public source for information pertaining to the Affordable Care Act and health insurance coverage is www.HealthCare.gov. HealthCare.gov provides individuals seeking assistance with applying for health insurance coverage with a 24/7 toll-free call center (1-900-318-2597) and 24/7 website chat. In-person assistance in the form of navigators, non-navigator assistance personnel, certified application counselors, and insurance agents and brokers will also available to provide important information on health care coverage options, health care access points, and enrollment. More information on where to find in-person assistance can be found on HealthCare.gov.

2.6 Should PLWH who currently receive services through RWHAP talk to their ADAP enroller before going to the State-based Health Insurance Marketplace to purchase health insurance? Yes, RWHAP clients should work with their ADAP eligibility specialist to discuss the most appropriate coverage options.

2.7 If a plan does not include any RWHAP or HIV providers can a person with HIV switch plans or is there any recourse to access HIV care?

It is critical that PLWH carefully weigh all of their options when choosing a health plan to ensure the HIV and other services they require are included in the plans they are considering. If you wish to continue seeing your current RWHAP provider, you must confirm that they are considered an in-network provider with your new insurer. Once a person enrolls in a health insurance plan, he or she cannot switch plans unless he or she qualifies for a special enrollment period based on a qualifying life event, such as moving to a new state, eligibility changes for premium tax credits and/or cost-sharing reductions, or loss of employer-sponsored coverage. Once a client is enrolled in a private health plan, RWHAP funds may only be used to pay for any services not covered, or partially covered, by the client’s private health plan. PLWH cannot utilize RWHAP funded services solely because their current provider is not in-network with their new plan. If they are eligible for coverage through the Marketplace, they must find coverage to meet their needs.

Last Updated: 9/04/2014
2.8 Is it suggested that a client take the premium tax credit upfront when enrolling in the Marketplace?
Every client must review their individual circumstances to decide on the best choice. Advance payments of the tax credits can be used right away to lower the client’s monthly premium costs. If a client qualifies for a tax credit, he or she may choose how much advance credit payments to apply to his or her premiums each month, up to a maximum amount. When clients apply for coverage in the Marketplace, it is important for them to double check the information they put on their application. If the amount of their expected annual income they report is not accurate, they may not get the right amount of savings. If they wind up making more money than they predicted on their application, they could have to pay back some or all of the savings they received. Learn more about premium tax credits and how clients can estimate income for their Marketplace application: https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/#question=what-if-my-income-turns-out-to-be-different-from-what-i-estimate.

2.9 Will the help with Marketplace and Medicaid enrollment end after open enrollment is over, or could a grantee build this activity into their program long term?
RWHAP grantees are encouraged to continue to assist clients with Marketplace and Medicaid enrollment throughout the year. Although the initial open enrollment period closed on March 31, 2014, some individuals may qualify for special enrollment periods. Further, the next annual open enrollment in the Marketplace will begin on November 15, 2014 and run through February 15, 2015. In addition, Medicaid enrollment will continue throughout the year and is not confined to the Marketplace’s open enrollment periods. Building outreach and enrollment activities into their program long-term can further ensure RWHAP funds are used by grantees in a cost-effective way.

2.10 What are the factors that may be discussed with clients when they’re making their choice of Qualified Health Plans?
In addition to the required cost-effectiveness test that the Ryan White HIV/AIDS Program grantees must consider, grantees may let clients know about a number of other factors that would affect their choice of plans, such as whether the state ADAP or Local AIDS Pharmaceutical Assistance Program (LPAP) has elected and/or is able to provide premium and cost sharing assistance for that specific plan, availability of Marketplace premium tax credits and cost-sharing reductions, the range of providers included in the provider network, whether the client’s drugs are included in the plan’s drug coverage and associated copayments and coinsurance for such drugs, and geographic coverage.

2.11 Can an individual enroll in a self-only plan and enroll his or her family members in a different plan through the Marketplace to ensure that RWHAP only pays for the insurance premiums for the eligible party, if it is determined to be cost-effective?
Yes. Once a family applies for coverage through the Marketplace and is determined eligible for a Qualified Health Plan, they can select different plans for different family members. Also, if a family has more than one plan, any advance payment of premium tax credit (APTC) is allocated to each plan by the Marketplace according to a business rule described in 45 C.F.R. 155.340(f). To learn more about how to select different plans for different family members, please review the following document: http://hab.hrsa.gov/affordablecareact/differentplansforfamilymembers.pdf.
3. Co-pays, Deductibles, and Premium Assistance

3.1 If a client is eligible for Medicaid, but is currently insured by an employer-sponsored plan, can RWHAP grantees continue to pay for insurance premiums and additional coverage completion in order to keep clients in their employer-sponsored plans?

Yes. If a client has access to employer-sponsored coverage, the client is not required to shift to Medicaid, even if eligible. RWHAP may continue to assist the client through an employer sponsored plan if it is determined to be cost effective.

3.2 How detailed does the cost-effectiveness analysis need to be? What type of documentation of this analysis needs to be provided?

When conducting cost-effectiveness analyses for premium assistance, grantees and subgrantees are encouraged to analyze the formulary adequacy and other essential medical benefits, the cost of the premium, and the effect of any cost-sharing reductions on the overall cost of the qualified health plan. HAB will expect a grantee to document its process and apply it consistently. Types of documentation may be determined by grantees.

3.3 If the RWHAP Part B ADAP is paying for a premium, can Parts C or D pay co-pay or co-insurance?

Yes, the RWHAP Part B ADAP premium assistance is not related to Parts C and D co-pay or co-insurance assistance. It is important to track the amount a Part C client spends on co-pay, co-insurance, and other medical expenses because they should not exceed the established cap on charges, which is based on Federal Poverty Level.

3.4 For RWHAP Part A Grantees, can Part B/ADAP medication costs be included in the cost-effectiveness assessment?

Yes, cost-effectiveness analyses may include expenses incurred by all Parts of the Ryan White HIV/AIDS Program.

3.5 Regarding Policy Clarification Notice 13-05: What limits are there for the co-pays/deductibles in private insurance for which RWHAP funds may be used?

RWHAP funds may be used to cover premium and cost sharing costs for private insurance plans. Funds may also be allocated to state ADAP programs to manage premium assistance for clients. In all cases, the RWHAP grantee must do a cost effectiveness analysis to determine if the payments exceed the cost of providing RWHAP services. Funds may not be used to pay for any administrative costs outside of the premium payment of health plans.

3.6 Can RWHAP funds be used to pay premiums for tiered policies?

Yes. Ryan White HIV/AIDS Program funds may be used for premium assistance for tiered policies as long as it is cost-effective. RWHAP funds may only be used to purchase and maintain health insurance that is cost-effective. In determining which qualified health plans in the Marketplace are cost-effective for clients eligible for cost-sharing reductions, grantees and subgrantees are encouraged to analyze the formulary adequacy and other essential medical benefits, the cost of the premium, and the effect of any

Last Updated: 9/04/2014

3.7 In Part A, can RWHAP funds be used to pay for higher “tiered” copayments in “tiered” networks (i.e., networks that require individuals to pay more to see some providers)? Yes, RWHAP funds may be used to pay for higher copays and deductibles within “tiered” networks, since providers in any covered tier are not considered out-of-network. Grantees must consider availability of resources prior to making such allocations. Specific to RWHAP Part A grantees, this determination will be made by the Planning Council as part of its priority setting/resource allocation processes and implemented by the grantee.

3.8 Should funds used to cover premiums or cost sharing be categorized under the early intervention service category as well as the core medical services category? For RWHAP Parts A, B, and C, funds used to cover premiums or cost sharing are only considered core medical services under the category of health insurance premium and cost-sharing assistance. Part D does not have a designation in the legislation regarding “core medical services.” Therefore, premium cost sharing by Part D cannot be designated as a “core medical service.”

3.9 Can you explain how out-of-network service affects RWHAP? RWHAP funds may NOT be used to pay for services a client receives out-of-network, unless they are services that a client could NOT have obtained from an in-network provider. For example, Mr. Sanchez needs resistance testing. He has ABC insurance, which will pay for the test, and he is also a RWHAP client. Lab A is in-network, but it is across town from Mr. Sanchez. Mr. Sanchez chooses to go to Lab B because it is closer, but it is not in-network with ABC insurance. Thus, RWHAP funds may NOT be used to cover Mr. Sanchez’s test because he could have received that test from an in-network provider and had the service paid for by ABC insurance.

3.10 In Part A, can RWHAP funds be used to pay for higher “tiered” copayments in “tiered” networks (networks that require individuals to pay more to see some providers)? Yes, RWHAP funds may be used to pay for higher copays and deductibles within “tiered” networks, since providers in any covered tier are not considered out-of-network. Grantees must consider availability of resources prior to making such allocations. Specific to RWHAP Part A grantees, this determination will be made by the Planning Council as part of its priority setting/resource allocation processes and implemented by the grantee.

3.11 Can RWHAP Part B ADAP rebates be used to pay for premiums, copayments, and deductibles? Yes. ADAPs can use rebate dollars to pay for premiums, copayments, and deductibles. If an ADAP chooses to pay Medicaid prescription copays and prescription deductibles for an ADAP-eligible person, the ADAP cannot collect the 340B rebate as that would be double-dipping.
3.12 For PLWH, including those who are below 400 percent of Federal Poverty Level (FPL; but above 133 percent of FPL) who receive insurance through the Health Insurance Marketplace at a discounted rate, can RWHAP dollars be used to pay for insurance premium, deductibles, and co-pays?
Yes, Parts A, B, C, and D of the RWHAP will still be able to assist clients with co-pays, insurance premiums, and deductibles in allowable circumstances and as part of core medical services. Please see Policy Clarification Notice 13-05 and 13-06 for more information on using RWHAP funds for this purpose. The HIV/AIDS Bureau projects that this core medical service will increasingly be a priority. This is based on a review of the need, circumstance, and cost-effectiveness of assisting with full insurance coverage.

3.13 My state uses the Federally-facilitated Marketplace and is not expanding Medicaid at this time. We currently use RWHAP dollars for premium assistance. Will we still work directly with the insurance companies to pay for premiums following the Affordable Care Act implementation?
Yes, you will continue to work directly with the health insurance companies, including making direct payments to the health insurance company for premiums, co-payments, and deductibles.

3.14 If a client receives assistance with premiums through the Marketplace, can he or she also request additional assistance with premiums through RWHAP’s Health Insurance Continuation services program?
Yes, RWHAP is able to assist clients who receive assistance with health insurance premiums (premium assistance, tax subsidies, etc.). Clients should check with their RWHAP Part to determine if such support is available. See Policy Clarification Notices 13-05 and 13-06 for more information on using RWHAP funds for this purpose.

3.15 How will premium assistance payments occur in both the State-based Marketplace and the Federal Marketplace?
State-based marketplaces have the flexibility to implement a process for premium aggregation. Any entity including a RWHAP grantee that wants to be able to pay premiums on behalf of an individual would need to work with the State-based marketplaces to develop or establish a process that will facilitate the aggregation of premium payments.
For at least the first year, the Federally-facilitated Marketplace will not establish a process that facilitates premium sponsorship or allows organizations to pay premiums on behalf of enrolled individuals. Any organization that wants to make such payments will need to work directly with the issuers (health insurer) or with the individuals to help pay these premium payments. As always, cash payments to individuals are not allowable.
4. General: Ryan White and the Affordable Care Act

4.1 What is the individual shared responsibility payment? Who is exempt from the shared responsibility payment? What is the process for receiving an exemption from the shared responsibility payment?

Under the Affordable Care Act, individuals who are not enrolled in a health plan that qualifies as minimum essential coverage may have to pay a fee (the “individual shared responsibility payment”). Individuals may be exempt from paying this fee if they (1) are members of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits and adhere to the tenets of that sect; (2) are members of a recognized health care sharing ministry; (3) are members of a federally recognized Indian tribe; (4) have household income below the minimum threshold for filing a tax return; (5) only went without the required coverage for a short coverage gap of less than three consecutive months during the year; (6) were certified by a Health Insurance Marketplace as having suffered a hardship that makes them unable to obtain coverage; (7) cannot afford coverage because the minimum amount the individual must pay for premiums is more than eight percent of the individual’s household income; (8) are in jail, prison or similar penal institution or correctional facility after the disposition of charges; and (9) are not U.S. citizens, U.S. nationals, or aliens lawfully present in the U.S. See IRS, Questions on Individual Shared Responsibility Provision Question #21: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

In order to receive an exemption, individuals may claim it when they file their taxes or when they apply for coverage through the Marketplace depending on the type of exemption. For more information, see healthcare.gov: https://www.healthcare.gov/exemptions/.

4.2 Who can qualify for a “hardship” exemption and not have to make the individual responsibility payment?

Individuals who have any of the following circumstances that affect their ability to pay for health insurance coverage may qualify for “hardship exemptions:” (1) they were homeless; (2) they were evicted in the past 6 months or were facing eviction or foreclosure; (3) they received a shut-off notice from a utility company; (4) they recently experienced domestic violence; (5) they recently experienced the death of a close family member. (6) they experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to their property; (7) they filed for bankruptcy in the last 6 months; (8) they had medical expenses they couldn’t pay in the last 24 months; (9) they experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member; (10) they expect to claim a child as a tax dependent who’s been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, they do not have the pay the penalty for the child; (11) As a result of an eligibility appeals decision, they’re eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on their monthly premiums, or cost-sharing reductions for a time period when they weren’t enrolled in a QHP through the Marketplace; (12) they were determined ineligible for Medicaid because their state didn’t expand eligibility for Medicaid under the Affordable Care Act; and (13) Their individual insurance plan was cancelled and they believe other Marketplace plans are unaffordable. For more information on the exemption process, see healthcare.gov: https://www.healthcare.gov/exemptions/.
4.3 What if a client doesn’t enroll in minimum essential coverage?
Under the Affordable Care Act, individuals who are not enrolled in a health plan that qualifies as minimum essential coverage may have to pay a fee that increases every year. The fee in 2014 is calculated one of two ways. The client will pay whichever of these amounts is higher:

- 1% of yearly household income. The maximum penalty is the national average yearly premium for a bronze plan.
- $95 per person for the year ($47.50 per child under 18). The maximum penalty per family using this method is $285.

In 2015, the fee is 2% of income or $325 per person. In 2016 and later years it’s 2.5% of income or $695 per person. After that it is adjusted for inflation. If a client is uninsured for just part of the year, 1/12 of the yearly penalty applies to each month he or she uninsured. If the client is uninsured for 3 months or less, the client does not have to make a payment. For additional information, see healthcare.gov: https://www.healthcare.gov/what-if-i-dont-have-health-coverage/.

4.4 Please describe modified adjusted gross income (MAGI).
MAGI is the figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, modified adjusted gross income is an individual’s adjusted gross income plus any tax-exempt Social Security, interest, or foreign income he or she may have. MAGI is based on federal tax rules for determining adjusted gross income (with some modification). MAGI will be used for most Medicaid/CHIP enrollees, including children, pregnant women, parents, and the new adult group. In addition, MAGI will be used to determine eligibility for premium tax credits and cost-sharing reductions for purchasing qualified health plans through the Health Insurance Marketplace. In most Medicaid cases, MAGI will not apply to the elderly, individuals with disabilities, those receiving or treated as receiving Supplemental Security Income, and the medically needy. Eligibility determinations for MAGI-excepted Medicaid groups will be made using current methods. Grantees and subgrantees are encouraged to contact their state Medicaid agency to learn more about how MAGI will be implemented in their state.


For more details on MAGI, you can also refer to the archived webcast on the Ryan White Program and Understanding MAGI that HAB co-hosted with CMS or view the slides:
http://services.choruscall.com/links/hrsa131120.html
http://hab.hrsa.gov/affordablecareact/webinars/index.html

4.5 Is there an online MAGI calculator?
Since MAGI is implemented with slight differences in each state, there is no universal online MAGI calculator. It is possible that your state may have an online calculator, so grantees are encouraged to contact their state Medicaid agency to learn more about how MAGI will be implemented in their state and to see if their state offers an online calculator.
4.6 Can clients change plans purchased from the Marketplace after they enroll?
Clients can change to a new health plan during Open Enrollment if their coverage has not taken effect yet. Open Enrollment for 2014 Marketplace coverage ends March 31, 2014. The next Open Enrollment period for 2015 coverage is November 15, 2014 through February 15, 2015.

To learn more about changing plans during open enrollment, visit https://www.healthcare.gov/what-if-i-want-to-change-marketplace-plans-after-i-enroll/.

After Open Enrollment ends, individuals can only enroll in new Marketplace coverage if they have a qualifying life event that gives them a special enrollment period. Qualifying life events that may trigger a special enrollment period include:

- Getting married
- Having, adopting, or placement of a child
- Permanently moving to a new area that offers different health plan options
- Losing other health coverage (for example due to a job loss, divorce, loss of eligibility for Medicaid or CHIP, expiration of COBRA coverage, or a health plan being decertified). Note: Voluntarily quitting other health coverage or being terminated for not paying premiums are not considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage.
- For people already enrolled in Marketplace coverage, having a change in income or household status that affects eligibility for tax credits or cost-sharing reductions

Individuals who do not qualify for a special enrollment period must wait for the next Open Enrollment period to enroll in a Marketplace plan. The next Open Enrollment period for 2015 coverage is November 15, 2014 through February 15, 2015. To learn more about how to qualify for special enrollment period, please visit https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/#part=1.

It is important to remember that individuals can apply for Medicaid or CHIP at any time and, if eligible, can enroll right away.

4.7 Do young adults who have the option of remaining on their parent’s coverage until age 26 have the option of seeking other coverage options?
Remaining on a parent’s insurance plan until age 26 is optional. Young adults are able to seek their own health insurance in the Health Insurance Marketplace or may be eligible for Medicaid. Low-income individuals may qualify for cost-sharing or premium assistance through RWHAP if they seek insurance on their own.

4.8 How should grantees conduct cost-effectiveness analyses to determine if RWHAP funds are best spent on cost-sharing for premiums, co-pays and deductibles?
Grantees may develop their own methodologies for determining cost-effectiveness. However, the analyses must meet the requirements outlined in Policy Clarification Notices 13-05 and 13-06: The grantee must determine how to operationalize the health insurance premium and cost-sharing assistance program, including the methodology used by the grantee to: (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics.
from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate primary care services. In order to use Part B ADAP funds to purchase health insurance, State ADAPs must be able to document for HRSA/HAB the methodology used by the State to: (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications

Grantees are encouraged to utilize existing methodologies to simplify their processes. For examples of such methodologies, please see below:


4.9 How should Ryan White HIV/AIDS Program (RWHAP) grantees (including AIDS Drug Assistance Programs or ADAPs) handle same sex marriages if they decide to align their RWHAP financial eligibility requirements with the new Affordable Care Act Modified Adjusted Gross Income (MAGI)-based methodologies?
Same-Sex Marriage and MAGI Alignment FAQ (PDF - 47 KB): http://hab.hrsa.gov/affordablecareact/samesexmarriagemagi.pdf

4.10 For patients assessed and deemed ineligible for state exchanges, will we need to have to get an IRS certificate of exemption? Will this be required by HRSA and will it be looked for during a site visit?
Grantees are expected to maintain policies regarding their required process for the pursuit of enrollment in health care coverage for all clients. These policies must include how the process will be documented by the grantee (including whether the grantee requires an exemption certificate as documentation). The expectation is that grantees have established these policies to ensure they are vigorously pursuing client enrollment in health care options and can document this process in a way that HRSA/HAB would be able to monitor when a site visit is conducted. For more information on exemptions, including when and how a patient receives an exemption certificate, please see the IRS’ questions on Individual Shared Responsibility Provision, Question #21: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
4.11 Many RWHAP Programs use gross income as a benchmark for eligibility. Will the programs have to change to modified adjusted gross income (MAGI) to align with the Affordable Care Act? Grantees are strongly encouraged to align their financial eligibility requirements with MAGI to reduce the burden on clients. HRSA/HAB understands that changing financial eligibility requirements will take time and there is no deadline or required timeframe to make this change.

4.12 Can a patient continue to receive medical services from a RWHAP provider who is out of network if the other providers in network are not RWHAP providers? RWHAP will only pay for medical services that are not covered or are only partially covered by a patient’s health insurance. If a patient is covered for a needed service, he or she must go to a network provider to receive those services, even if none of the providers are also RWHAP providers. Patients must review their coverage options and select a plan that includes their current RWHAP provider and/or will give them the best access to HIV/AIDS care.

4.13 Were Policy Clarification Notices 13-01 through 13-06 modified since they were originally issued? If so, when will these modifications be available? Policy Clarification Notices 13-05 and 13-06 were modified on June 6, 2014 to update guidance for grantees related to the health insurance premium and cost-sharing assistance program. Policy Clarification Notices 13-03 and 13-04 were modified slightly on September 13, 2013; Policy Clarification Notice 13-01 was modified on December 13, 2013. These modifications were minor; we changed only a few words to clarify and ensure consistency between policies. The revised Policy Clarification Notices are posted on the HAB Affordable Care Act page: http://hab.hrsa.gov/affordablecareact/index.html.

4.14 How can homeless clients demonstrate eligibility as part of the initial and recertification screenings for the RWHAP? All RWHAP grantees across all Parts must engage in eligibility determination and recertification. It is the expectation of the HIV/AIDS Bureau that at least once a year (whether defined as a 12-month period or a calendar year), the recertification procedures include the collection of more in-depth supporting documentation, similar to that collected at the initial eligibility determination. Documentation and the process for proof of residency for homeless clients are determined by the grantee. For example, a grantee may allow homeless clients to provide proof of residency through documentation from a local community service organization, such as a homeless shelter, that indicates that the homeless client receives services from the establishment.
4.15 What if an unstably housed, homeless or imminently homeless client has become eligible for Medicaid or private health insurance as a result of the Affordable Care Act? He/she receives the majority of his/her care at a local RWHAP-funded AIDS Service Organization (ASO). The services that the client receives include: primary medical care, infectious disease, substance abuse and mental health treatment, medical case management, and medical transportation. Unfortunately, the client’s health insurance carrier network does not include the ASO or the individual clinicians that the client is currently seeing. Can the client continue to receive the aforementioned services and have the RWHAP pay for them?

Once an individual is enrolled in Medicaid or private insurance, RWHAP funds may only be used to pay for any service which Medicaid or private health insurance does not cover or only partially covers, as well as premiums, co-pays and deductibles, if required.

4.16 If a client’s recertification would normally occur at the end of August, could the grantee push that client’s recertification process forward to October to align with the Affordable Care Act enrollment process?

We encourage grantees to seek opportunities to align existing RWHAP recertification processes with their Affordable Care Act outreach and enrollment activities.

4.17 Could you please provide guidance regarding the tax credits associated with the Affordable Care Act? If I understand this section of the Affordable Care Act correctly, premium tax credits will be both refundable and “advanceable.” So, if a RWHAP client chooses the reimbursement in a “lump sum” after they file their Federal income tax, with the assumption that RWHAP will pick up the costs during the year. If the client receives a reimbursement on their taxes, will RWHAP Part A be eligible for the reimbursement from that client? Some RWHAP clients have Federal debt, and, therefore, the Federal government keeps their “refund.” Is HRSA going to make it a requirement that clients must elect to receive an “advanceable” tax credit in order to participate in the program?

A refundable tax credit is one that is available to a person if he or she has no tax liability. An “advanceable” tax credit allows a person to receive assistance at the time that he or she purchases insurance rather than paying his or her premium out of pocket and waiting to be reimbursed after filing his or her annual income tax return. Advance premium tax credits will reduce the premium amount an individual owes each month for health insurance coverage. They are available to eligible individuals with household incomes between 100% and 400% of the FPL (400% FPL is $45,960 for an individual and $94,200 for a family of four in 2013), and individuals who don’t qualify for other health insurance coverage providing “minimum essential coverage.” Premium tax credits are paid each month by the Federal government to the insurer and reconciled on the taxpayer’s tax return after end of year. The HIV/AIDS Bureau Policy Clarification Notice #13-05 addresses advance premium tax credits and states that many RWHAP clients with incomes between 100% to 400% of the FPL without access to certain types of minimum essential coverage may be eligible for premium tax credits to offset the cost of purchasing a qualified health plan through their State’s Marketplace. Individuals who qualify may choose how much advance credit payments to apply to their premiums each month, up to a maximum amount. If the amount of advance credit payments they get for the year is less than the tax credit...
they’re due, they’ll get the difference as a refundable credit when they file their Federal income tax return. If a client’s advance payments for the year are more than the amount of his or her credit, he or she must repay the excess advance payments with his or her tax return.

HRSA/HIV/AIDS Bureau will be issuing more information on the question related to both reconciliation and debt in the future.

4.18 Are RWHAP grantees and subgrantees that use program funds to purchase health insurance required to recoup any premium and cost-sharing refunds a client may receive from his or her private health plan?

Under exceptional circumstances, Marketplaces may allow individuals to receive retroactive advance payments of the premium tax credit and cost-sharing reductions. CMS will pay advance payments of the premium tax credit and cost-sharing reductions to the Marketplace Qualified Health Plan (QHP) issuer on a retroactive basis based on the effective enrollment date established by the Marketplace. The Marketplace QHP issuer must collect and adjudicate the claims incurred by the individual starting from the retroactive enrollment date and must credit or refund to the enrollee any excess cost-sharing or premium payments made by or for the enrollee. For more information see http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf

RWHAP grantees and subgrantees that use program funds to purchase health insurance for clients must establish appropriate mechanisms to vigorously pursue any premium and cost-sharing refunds an individual client receives from their health plan issuer. RWHAP grantees and subgrantees must establish and maintain policies and procedures for the pursuit of such refunds from individual clients. Grantees and subgrantees must document the steps that were taken to recoup premium and cost-sharing refunds from clients.

4.19 Are RWHAP grantees and subgrantees that use program funds to purchase health insurance required to recoup the Medical Loss Ratio rebate a client may receive from his or her private health plan?

Most insurance companies are required to spend at least 80% of the money received from premiums on health care and quality improvement activities. Only 20% or less can be spent on administrative, overhead, and marketing costs. This is known as the 80/20 rule, or Medical Loss Ratio (MLR). Insurance companies that do not meet the MLR because they have spent more than 20% of premiums on administrative, overhead and/or marketing costs must provide individuals with a rebate. See https://www.healthcare.gov/how-does-the-health-care-law-protect-me/#part=10 for more information on MLR.

RWHAP grantees and subgrantees that use program funds to purchase health insurance for clients must establish appropriate mechanisms to vigorously pursue any medical loss ratio rebates an individual client receives from their health plan issuer. RWHAP grantees and subgrantees must establish and maintain policies and procedures for the pursuit of such rebates from individual clients. Grantees and subgrantees must document the steps that were taken to recoup medical loss ratio rebates from clients.
4.20 Does HRSA require a Notice of Eligibility Determination to be placed in all client files? Policy Clarification Notice 13-03 encourages RWHAP grantees to consider requiring proof of the Medicaid/Marketplace notice of eligibility determination; however, it will be a Program decision on whether and how to do this. Regardless, HRSA still requires the RWHAP eligibility documentation outlined in Policy Clarification Notice 13-02.

4.21 Our State is working hard to prepare for getting our uninsured clients enrolled in coverage under the Affordable Care Act, but we can’t guarantee 100% success in this effort given factors outside of our control. What expectations does HRSA have for how quickly grantees must transition uninsured patients into new coverage either through Marketplace or expanded Medicaid (in applicable states)?

We understand that there will be a great deal of effort put forth by all grantees to assist clients’ enrollment into new health insurance options. As stated in Policy Clarification Notices #13-01 and 13-04, all grantees need to work vigorously to enroll all eligible clients. The HIV/AIDS Bureau is requiring grantees to develop policies and standard operating procedures to accomplish this and to document the steps which they will utilize to enroll clients. This process will be reviewed by HRSA during future site visits to RWHAP grantees.

4.22 What does the HIV/AIDS Bureau mean by “vigorously pursue” enrollment?

The HIV/AIDS Bureau’s expectation is that RWHAP grantees and subgrantees will make every reasonable effort to ensure all uninsured clients are assessed for all options in both public and private health care coverage. This includes Medicaid, Medicare, and any other private health insurance options. Clients must be informed about consequences of not enrolling in either public or private health insurance coverage options. Also, grantees are expected to maintain policies regarding their required process for the pursuit of enrollment in health care coverage for all clients. These policies must include how the process will be documented by the grantee. If a grantee has subgrantees, this policy must also include steps that will be taken to monitor subgrantee implementation of the policy. If after extensive efforts, a client remains unenrolled in health care coverage, the client may be served by RWHAP. The expectation is that grantees have established these policies to ensure they are vigorously pursuing client enrollment in health care options and can document this process in way that the HIV/AIDS Bureau would be able to monitor when a site visit is conducted. RWHAP remains the payer of last resort, and grantees are expected to maximize all resources and health care dollars in order to serve the most patients/clients.

4.23 What will happen to RWHAP now that the Affordable Care Act has been implemented? Is RWHAP going to disappear?

The authorization for the RWHAP expired on September 30, 2013. The Program will not sunset and can continue to operate through Congressional appropriations with or without subsequent legislation. The decision of whether or not to pursue reauthorization of RWHAP rests with Congress.
4.24 Will Part A grantees have flexibility to assist clients with enrollment into health plans in the Marketplace? For example, can we change our Medical Case Management to Non-Medical Case Management services and reduce the amount of funding directed toward core medical services? The EMA does not have a core medical services waiver currently in place.
RWHAP Part A grantees are encouraged, working with their Planning Council, to modify their system of care to meet needs identified in the jurisdiction. Please refer here for guidance on the flexible utilization of RWHAP funds for outreach and enrollment activities:

EMAs/TGAs that do not have an approved core medical services waiver for a grant year must adhere to the 75/25 requirement. If you wish to expend less than 75 percent on core medical services, you must submit a request for a waiver. More information on submitting a waiver can be found in Policy Clarification Notice 13-07.

4.25 Will HRSA consider lining up with the Medicaid annual eligibility determination instead of the currently required six month eligibility determination?
To maintain eligibility for RWHAP services, clients must continue to recertify at least every six months. The primary purpose of the recertification process is to ensure that an individual’s residency, income, and insurance status continues to meet the grantee eligibility requirements and to verify that RWHAP is the payer of last resort.

Grantees have flexibility with regard to timing and process, especially in consideration of Health Insurance Marketplace enrollment periods, but all RWHAP Parts must engage in eligibility determination and recertification. It is the expectation of the HIV/AIDS Bureau that at least once a year (whether defined as a 12-month period or calendar year), the recertification procedures include the collection of more in-depth supporting documentation, similar to that collected at the initial eligibility determination. Please see Policy Clarification Notice 13-02 for additional details:

4.26 Does HRSA expect that RWHAP funds for case management will continue to be available now that the Affordable Care Act is fully implemented? If funds will be available to continue this work, will there be any changes to the way it is implemented?
RWHAP Program funding will continue to be issued based on the current legislation. Under current law, RWHAP funds for Medical Case Management services (including treatment adherence) and Non-Medical Case Management will continue to be available after the implementation of the Affordable Care Act.

4.27 I missed one of the Affordable Care Act webinars the HIV/AIDS Bureau offered. Are the slides posted online?
Webinars and the corresponding slides are recorded and available on the HIV/AIDS Bureau webpage, “Ryan White and the Affordable Care Act: What You Need to Know.”
http://hab.hrsa.gov/affordablecareact/index.html
4.28 If my private non-profit Part C clinic contracts with our local Federally Qualified Health Center (FQHC), will they still be eligible for the 340B program if they no longer receive Part C grant funds?
Yes, FQHC entities are eligible for participation in the 340B program. Please visit:

4.29 Will individuals who are exempt from purchasing insurance in the Marketplace or are considered exempt by the Internal Revenue Service (IRS) be eligible for RWHAP services?
Under the Affordable Care Act, starting in 2014, most individuals who do not enroll in minimum essential coverage will be required to pay an individual responsibility penalty. Some individuals may be exempt from the Affordable Care Act’s requirement to enroll in health coverage. In these circumstances, the Health Insurance Marketplace or the IRS will provide individuals with certificates of exemption if they meet certain criteria. Individuals who receive an exemption from the Marketplace or IRS will be considered uninsured and therefore if eligible, RWHAP would be the payer of last resort. For a list of criteria that may qualify individuals for an exemption visit http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision. Also, see Policy Clarification Notice 13-04 for more information on how exempt individuals may be served by the RWHAP

4.30 Where can I find technical assistance related to the Affordable Care Act?
The HIV/AIDS Bureau has hosted numerous Affordable Care Act webinars targeting RWHAP grantees and stakeholders, including a webinar targeting HIV providers and network participation. Visit http://hab.hrsa.gov/affordablecareact/index.html to review the archived webinars. The HIV/AIDS Bureau also has an Affordable Care Act webpage on the HIV/AIDS Bureau website where RWHAP grantees may find recently posted Affordable Care Act related guidance including letters, Policy Clarification Notices and links to Affordable Care Act educational tools:
http://hab.hrsa.gov/affordablecareact/index.html
Additionally, there are a significant number of technical assistance resources found on the TARGET Center website. You may also visit the Centers for Medicare & Medicaid Services (CMS) training website:

4.31 If a client is already enrolled in Medicaid, must he or she still fill out the application for the Marketplace to make sure he or she is still eligible for the same benefits?
If a client is already enrolled in Medicaid and continues to be eligible for Medicaid, he or she may remain in Medicaid. No further action is required.

4.32 What allowable expenses can RWHAP grantees provide to patients?
In addition to providing the core medical Services necessary for eligible individuals to treat their HIV infection, the RWHAP also allows for the provision of support services to help clients remain in care. RWHAP only pays for services that are not covered by other public and private insurance. Please see Policy Clarification Notice 10-02 for more information on allowable costs click http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf. Also, the Outreach, Enrollment, and Benefits Counseling letter on the HIV/AIDS Bureau’s Affordable Care Act webpage has more information on these allowable services in the context of Affordable Care Act implementation.
4.33 How will RWHAP deal with persons who are categorically ineligible for coverage under the Affordable Care Act?
RWHAP provider will ask eligibility determination questions and will follow their established procedure to assess the client’s eligibility for other health care coverage options. The RWHAP remains the payer of last resort and RWHAP providers must assist the client to vigorously pursue all other health care coverage options.

4.34 Should grantees become Champions for Coverage?

4.35 Will the Affordable Care Act affect RWHAP client caps or discounted sliding scale fees?
No, when RWHAP is the primary payer, client caps and discounted sliding scale fees will not be affected by the Affordable Care Act.

4.36 Some health plans may require enrollees to obtain prior authorization for certain items or services before deciding whether to cover them. Can Ryan White HIV/AIDS Program funds be used during a prior authorization period?
If a health plan requires a prior authorization for a particular item or service, RWHAP funds may be used to cover such item or service only if funding is available and there is no reasonable expectation that the prior authorization will be approved. The grantee should base the reasonable expectation determination on past experience with prior authorization approvals or disapprovals for the same or similar items or services. If a grantee uses RWHAP funds to pay for an item or service during a prior authorization period and the health plan decides to cover the item or service, the grantee must make every reasonable effort to back-bill the health plan and be reimbursed for any RWHAP funds expended during the prior authorization process.

4.37 Can the Ryan White HIV/AIDS Program funds be used to pay for drugs, including combination medications, which are not included on a Qualified Health Plan’s formulary?
Yes. If an HIV-related medication is not covered by a Qualified Health Plan’s formulary, then the RWHAP may pay after a client has pursued an “expedited exceptions process.” Qualified Health Plans are required to have procedures in place to allow enrollees access to clinically appropriate drugs-- even if they may not be on their formulary. The covered individual and/or the individual’s physician must apply for an expedited exception through their health plan. Information about how to apply for an expedited exception can be found either on the health plan’s website or by calling the health plan. Health plans must decide within 24 hours of receiving a request for an expedited exception about whether or not to cover the drug(s). The RWHAP may cover the cost of the drug(s) for a person with HIV during the period the health plan is reviewing the exception request, and also if the health plan decides not to cover the drug(s) to ensure continuity of care for a person with HIV.
4.38 May a RWHAP grantee, including an AIDS Drug Assistance Program (ADAP), pay for a combination antiretroviral medication for a RWHAP-enrolled client who has a health insurance plan that does not cover a combination antiretroviral medication, but does cover all of the single medication components of the combination medication?
Yes. RWHAP may pay after a client has pursued an “expedited exceptions process” (see Question 4.37 for more information on this process). A RWHAP grantee, including an ADAP, may pay for the combination antiretroviral medication for a covered client if the grantee can demonstrate that the individual components covered by the client’s insurance are not equivalent to the combination antiretroviral medication in regard to medical impacts, such as side effects or patient adherence. Grantees are encouraged to document on an individual, case-by-case basis the need for the combination antiretroviral medication in these situations. The grantee must ensure the payment for the combination antiretroviral medication with grant funds is reasonable based on the medical impact on the client (i.e., increased treatment adherence, decreased side effects, decreased risk of transmission to others if the virus is adequately suppressed, etc.). The RWHAP funds remain payer of last resort.

5. Grants Management/Allowable Costs

5.1 Is benefit and entitlement counseling that is conducted as part of outreach for the Affordable Care Act considered a core medical service?
It can be, if it is conducted within the framework of a Ryan White HIV/AIDS Program-funded service that is considered a core medical service. For example, helping a person enroll in Medicaid under the Affordable Care Act can be a core medical service when it is provided as part of medical case management, as long as the other key activities of medical case management are also being conducted. These activities, which are outlined in HAB Policy Clarification Notice 10-02, include:

- Initial assessment of service needs;
- Development of a comprehensive, individualized care plan;
- Coordination of services required to implement the care plan;
- Continuous client monitoring to assess the efficacy of the care plan; and,
- Periodic reevaluation and adaptation of the care plan, at least every 6 months, as necessary during the enrollment of the client.

Benefits and entitlements counseling is not a stand-alone service under the Ryan White HIV/AIDS Program. As such, it cannot be considered on its own as a core medical service. Also, when the benefits and entitlement counseling occurs as part of non-medical case management or referral services, it is considered a non-core (or support) service.

5.2 If intensive medical case management is not covered by Medicaid and/or private insurance, do we have to attempt to bill for it and be denied for every client before utilizing Ryan White HIV/AIDS Program funds to pay for it?
Grantees must review the components and activities of intensive medical case management funded by Medicaid and private insurance to determine what services are covered. RWHAP grantees must bill third
party payers as appropriate and use the Ryan White service model to provide the comprehensive medical case management that meets any uncovered and uncompensated case management needs as allowable under RWHAP statute and policies.

Once the grantee has determined that the service is not covered by Medicaid or private insurance, they do not need to bill for each client and receive a denial from Medicaid or private insurance. However, grantees must monitor all changes in coverage throughout the year to ensure that the service does not become covered and, therefore, billable.

5.3 If we have a privately insured patient whose insurance won’t pay for his/her labs, would Ryan White HIV/AIDS Program pay that bill as payer of last resort?
As is the current HAB policy, services for clients meeting established eligibility criteria that are not funded by other sources can be paid by RWHAP funds.

5.4 If a client lives a great distance from a lab accepting his/her insurance plan or Medicaid and cannot afford transportation, could we use Ryan White HIV/AIDS Program-funded transportation to assist the client in getting to his across town in-network lab?
Grantees should analyze overall program costs in aggregate to determine the best method of service delivery for clients with varying needs and different levels of coverage.

5.5 In a small Part D clinic where about 50% the HIV positive youth are uninsured, can funds that were budgeted to cover lab tests be allocated to assist with premiums for uninsured HIV positive youth in the Marketplace?
Yes, this is allowable. HRSA suggests the grantee carefully review its Part D budget to ensure the full range of services can be delivered, given the limited amount of RWHAP funds available for most Part D clinics, and to determine if this use of RWHAP funds is cost effective. The cost-effectiveness analysis should include an analysis of the formulary’s adequacy, what other essential medical benefits the plan covers, the cost of the plan’s premium, and the effect of any cost-sharing reductions that may be available on the overall cost of the qualified health plan. If the grantee decides to revise its budget, this change should be reviewed with the grantee’s Project Officer.

5.6 In Policy Clarification Notice #13-04, what does partially covered mean in the phrase, “Once enrolled in a private health plan, RWHAP funds may only be used for services not covered or partially covered by a client’s plan.”
It means that RWHAP can cover eligible costs not covered by the health plan. For example, if a client needs 12 treatment adherence visits, and his or her insurance only covers four treatment adherence visits, RWHAP funds can be used to pay for the remaining eight visits.

5.7 Would RWHAP Part A be able to fund additional staff to process insurance payments or would that need to come from administrative funds?
RWHAP grantees are allowed to use funds for insurance premiums and cost sharing, which includes co-pays and deductibles. In providing this assistance, the direct service to a client (e.g., the provision of insurance or processing payments to insurance companies on behalf of a client) would be considered an allowable program expense. This would not be part of the administrative cap. The cost of administering
the overall program (e.g., the staff required to process insurance claims or payments received for services from insurance companies) is considered administrative, and is subject to the cap.

5.8 We provide RWHAP Part B services specific to medical and non-medical case management. How can we obtain a list of covered Part B benefits under the Affordable Care Act to know what will still be covered by the Ryan White HIV/AIDS Program?
While the exact benefits that will be covered will vary by health insurance plan and by State, all plans offered through the Marketplace must provide the essential health benefits, which include at least: ambulatory patient services (outpatient care you get without being admitted to a hospital); emergency services; hospitalization, maternity, and newborn care (care before and after your baby is born); mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy); prescription drugs; rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills); laboratory services; preventive and wellness services and chronic disease management; and pediatric services. You can find out more about what plans cover at www.HealthCare.gov.

You will need to review the specific health coverage plans in your State to determine which specific services are not covered or partially covered as each health coverage plan may have a different level of coverage.

For more information about the Essential Health Benefits and RWHAP, you can also access the archived webinar at http://hab.hrsa.gov/affordablecareact/webinars/index.html.

5.9 If case managers are performing enrollment and benefits counseling, do we have to allocate dollars for case managers under both core medical services and support services?
If the service is being provided as a component of medical case management, it should be captured and reported as medical case management, which is a core medical service. If it is being provided as non-medical case management, it should be documented as a support service.

5.10 What about case management in states where there is no Medicaid expansion at this time? How will we provide those services and also ensure RWHAP is the payer of last resort?
Will case management be considered a specialty service?
In states where Medicaid is not expanding, RWHAP will continue to operate as it does today. Case management will continue to be important to ensure that people who are eligible for public or private health insurance plans are enrolled in health insurance and that RWHAP continues to be the payer of last resort.

5.11 RWHAP has a cap on charges for its clients based on their income. For clients who are below 100% of Federal Poverty Level, they are not allowed to be charged for services. For individuals who have plans that require a co-pay, who is responsible for paying that co-pay, CMS or the service provider?
The cap on charges applies only to services provided to clients when RWHAP is the payer. Individuals who have a health insurance plan (Medicaid or private insurance) must use their health insurance to pay
for services that the health insurance plan covers. The individual receiving care paid for by the health insurance plan is responsible for the required co-pay; however, it is allowable for RWHAP to assist the client in paying his or her co-pay. See Policy Clarification Notices 13-05 and 13-06 for more information on using RWHAP funds for co-pays, deductibles, and other cost-sharing.

5.12 If a patient who receives services through the RWHAP is eligible for enrollment in a health insurance plan in the Marketplace or through Medicaid, but chooses not to enroll, thereby incurring the penalty, will they be eligible then for RWHAP services again, even though that is the payer of last resort?
Because the Ryan White HIV/AIDS Program is the payer of last resort, RWHAP grantees and subgrantees must make every reasonable effort to ensure all uninsured RWHAP clients enroll in any health coverage options for which they may be eligible. Grantees are required to maintain policies regarding the required process for the pursuit of enrollment for all clients, to document the steps during their pursuit of enrollment for all clients, and to establish stronger monitoring and enforcement of subgrantee processes to ensure that clients are enrolled in coverage options for which they qualify. If after extensive documented efforts on the part of the grantee, the client remains unenrolled in health care coverage, the client may continue to receive services through RWHAP. See Policy Clarification Notices 13-01 and 13-04 for more information.

5.13 Please clarify whether it is individual or household income for eligibility determination.
The RWHAP grantee establishes the income guidelines for eligibility. The HIV/AIDS Bureau Policy Clarification Notice 13-03 recommends that RWHAP grantees consider updating financial eligibility to use Modified Adjusted Gross Income (MAGI), which is based on household income.

5.14 Can the Ryan White HIV/AIDS Program ADAPs pay for Medicare Part B premiums?
No. The Medicare Part B program does not have a formulary which the Ryan White HIV/AIDS Program (RWHAP) statute requires in order for an ADAP to provide insurance premium assistance. In addition, as a practical implementation matter, the deductions for Medicare Part B premiums are generally automatically deducted from the individual’s Social Security check (either retirement or SSDI, if disabled) and per statute, the RWHAP cannot make a payment to an individual.

5.15 Can the Ryan White HIV/AIDS Program ADAPs pay for Medicare Part C (called Medicare Advantage [MA]) plans?
It depends. The ADAP would first have to check whether the Medicare Part C plan covers prescription drugs and if it does, whether it has formulary equivalency with the ADAP core antiretroviral therapeutics and is cost-effective for the ADAP. Medicare Advantage Plans with prescription drug coverage are called “MA-Prescription Drugs (PDs).”
6. Medicaid/Medicaid Expansion

6.1 Can Ryan White HIV/AIDS Program funds be used to pay for Medicaid prescription co-pays on medications?
Policy Clarification Notice 13-01 states: “RWHAP funds may be used to pay for any medically necessary services which Medicaid does not cover or only partially covers, as well as premiums, co-pays, and deductibles if required.” Please also see Policy Clarification Notice 13-06 for more information on how to operationalize co-insurance and copayment assistance.

6.2 If a homeless client is located in a state that is not expanding Medicaid, how will the RWHAP services change?
While all states are not expanding Medicaid, all states will have a Health Insurance Marketplace. Private health insurance purchased through the Marketplace will result in expanded coverage options and expanded access to core medical services and prescription medications. RWHAP grantees must make every reasonable effort to ensure eligible uninsured RWHAP clients expeditiously enroll in private health insurance plans or Medicaid, if eligible, whenever possible and inform clients about any consequences for not enrolling. The RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered by public or private health insurance plans. RWHAP grantees and subgrantees should consider helping individual clients pay for premiums and/or cost-sharing, if cost effective.

6.3 My State is not expanding Medicaid. When RWHAP sunsets in September 2013, will there be special provisions for States where PLWH will not have access to the expanded Medicaid option?
RWHAP did not sunset in September 2013. It can continue to operate through Congressional appropriations with or without subsequent legislation. The decision of whether or not to pursue reauthorization of RWHAP lies with Congress. In States that choose not to expand Medicaid, the RWHAP will continue to provide medical and support services to those uninsured and underinsured individuals living with HIV.

6.4 What if our State is NOT accepting the Medicaid expansion funds? Will RWHAP be the only option for those patients? That will stretch our already flat RWHAP funds.
RWHAP is the payer of last resort for HIV-related services and will continue to serve uninsured and underinsured individuals living with HIV. RWHAP-funded providers/case managers need to continue to enroll potentially eligible clients in regular Medicaid as before. Individuals who are ineligible for Medicaid will be able to enroll in a private health plan offered in the Marketplace. Many of these individuals may qualify for Federal financial assistance (e.g. premium tax credits and cost-sharing reductions) to help them afford enrolling in a private plan in the Marketplace, which will reduce the burden placed on RWHAP. Those ineligible for federal assistance may remain uninsured and will continue to rely primarily on RWHAP. However, if resources are available, grantees and subgrantees may use RWHAP funds to pay for premiums and cost-sharing to help these individuals gain private coverage in the Marketplace when it is cost-effective and in accordance with RWHAP policy.
6.5 May RWHAP funds be utilized for Medicaid spend down?
Medicaid regulations indicate that there is no spend down when a third party, including RWHAP, pays for services. See 42 CFR § 435.831 (d).

6.6 Can a client enroll into expanded Medicaid coverage (up to 138% of FPL) outside of the Marketplace?
Yes. The Affordable Care Act has a “no wrong door” approach to enrollment such that individuals should only have to fill out one streamlined application to learn if they are eligible for Medicaid, CHIP, or a private health plan offered in the Marketplace, including eligibility for premium tax credits. Eligibility determinations will be coordinated between Medicaid and the Marketplace. If an individual applies for Medicaid outside of the Marketplace, the Medicaid agency will coordinate with the Marketplace to ensure that any individual determined ineligible for Medicaid is also assessed for eligibility for the Marketplace, including premium tax credits.

6.7 Where can I find state-specific information about Medicaid if my state is not expanding Medicaid?
To learn more about this information, please visit https://www.healthcare.gov/what-if-my-state-is-not-expanding-medicaid/

7. Qualified Health Plan Network Issues

7.1 In cases where there is more than one RWHAP-funded provider in the area, what strategies should RWHAP-funded providers use to become part of Qualified Health Plans (QHP)? In other words, what might motivate QHPs to contract with RWHAP-funded providers given the cost of HIV care?
The best strategy for joining a QHP network as a new provider is to begin negotiating with health plans as quickly as possible. Joining a network can be a lengthy process QHPs are not required to contract with all HIV/AIDS providers. Getting started as soon as possible is your best strategy. For more information on contracting with health plans and provider networks please visit http://hab.hrsa.gov/affordablecareact/faqs.html.

7.2 A center has one or more satellite offices. If the main site is on the Essential Community Providers (ECP) list, does the agency also need to have the satellite offices on the list?
That depends on the nature of the network membership. In some cases, the clinical provider must be listed, and in others, only the corporate entity needs to be listed. As your agency becomes a member of a network, be sure you know what is required.

7.3 Do we need to become ECPs for each insurance network we participate in?
We encourage you to become an ECP, although you are not required to do so for each network you participate in. However, it is important to ensure that you are “in network” for the insurance plans most used in your area in order to avoid losing access to your RWHAP clients who will shift to new coverage beginning in January 2014.
7.4 We are a RWHAP provider but we are not on the ECP list posted by CMS. How can we either get on the list or notify our availability to the QHPs?
Qualified Health Insurance Plans (QHPs or Issuer) will be permitted to write in ECPs not on the CMS-developed list for consideration as part of CMS certification review - that is, allowable write-ins will count toward the satisfaction of the minimum expectation or safe harbor standard.

The U.S. Department of Health and Human Services expects to monitor inclusion of ECPs in QHP provider network(s) over time, including providers that issuers write in, and will update this list in future years. Questions about the list may be directed to essentialcommunityproviders@cms.hhs.gov?subject=ECP List.

7.5 Can you talk a little more about the Essential Community Provider “write in” option? How does that work?
The current list of Essential Community Providers is non-exhaustive, and issuers may identify and write in other providers who meet the regulatory standard. View a list of current Essential Community Providers here: http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.


7.6 I have tried to update our information several times; could you send the link to update the information for Essential Community Providers?
CCIIO released a non-exhaustive list of Essential Community Providers. However, RWHAP providers should email CCIIO at EssentialCommunityProviders@cms.hhs.gov if they are not on the list or if their contact information is incorrect.