STATE OF MISSOURI
STATEWIDE SERVICES MANUAL

Developed by the Missouri Department of Health and Senior Services
Bureau of HIV, STD and Hepatitis

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PURPOSE:

The Missouri (MO) Statewide Services (SWS) Manual is intended to be used by Missouri Human Immunodeficiency Virus (HIV) Case Managers as a reference for the various policies and procedures related to Ryan White (RW) Statewide Services.

GOAL:

The goal of the Statewide Services Manual is to outline policies and procedures related to Statewide Services to ensure compliance with State and Federal mandates.

SUMMARY:

Statewide Services have established the following policies and procedures to ensure consistent criteria is used for eligibility and enrollment for client access to core HIV related medical services and to ensure compliance with State and Federal mandates.

POLICY:

1. Statewide Services are available to eligible clients at the discretion of the Department of Health and Senior Services (DHSS) or when funding permits.
2. Clients who request access to Statewide Services must be engaged in the MO HIV Case Management system (excluding the Direct Enrollment Services (DES) Program). (Subsection 8.1 and HIV Case Management Manual Section 3.0)
3. Statewide Services policies and procedures vary depending on individual program or Service category. (See individual program descriptions and policies for details.)
4. Documentation provided as part of the initial enrollment process into the MO HIV Case Management system may be used for Statewide Services eligibility documentation. Documentation includes: (HIV Case Management Manual Section 3.0)
    a. Proof of HIV+ status
    b. Proof of residency
    c. Proof of income, which meets current income requirements (0-300% Federal Poverty Level (FPL)).
5. Statewide Services cannot be provided to any individual who is over 300% of the FPL regardless of HIV Case Management enrollment status. (19 CSR 20-43.030)
6. Statewide Services referrals must be in "8ENR" status when services are rendered if requesting assistance.
7. An Exception Request may be submitted to the DHSS Benefits Administrator for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. Examples of delays may include client's ability to obtain and submit required eligibility documentation, delays in processing Statewide Services referrals, etc. There is no guarantee the Exception Request will be approved.
8. Clients who do not submit all required or requested documentation will not be eligible for Statewide Services.

9. DHSS may request additional information at any time before or after enrollment in any Statewide Services, or the DHSS Benefits Administrator may also ask for additional information on behalf of Statewide Service programs, as needed.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must upload all required MO HIV Case Management system eligibility documentation into the electronic client database before clients can become enrolled in requested Statewide Services. (HIV Case Management Data Rules)
3. Case Managers must enter all Statewide Services referrals into the "Service Referral" module in the electronic client database.
4. Case Managers must submit an Exception Request to the DHSS Benefits Administrator for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. (Examples of delays may include the client's ability to obtain and submit required eligibility documentation, delays in processing Statewide Services referrals, etc.)
5. The DHSS Benefits Administrator will review all required or requested documentation before Statewide Services enrollment.
6. The DHSS Benefits Administrator will activate requested Statewide Services referrals if approved.

DOCUMENTATION:

1. Proof of HIV Case Management eligibility (HIV Case Management Manual Section 3.0)
2. Statewide Services documentation, per individual policy
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following removal or closure policies and procedures have been established to ensure consistent criteria are used when it is necessary to address issues which could result in a client's suspension of Statewide Services.

POLICY:

1. The following conditions may result in permanent or time-limited removal or closure of Statewide Services:
    a. Endangering the life of a Case Manager(s), agency staff, public health official, etc.
    b. Threatening and/or abusive behavior
    c. Fraud
    d. Criminal activity on agency property
    e. Disrespectful or discourteous behavior
    f. Failure to meet eligibility requirements
    g. Failure to respond to requests for updated information
    h. Client has moved out of the state

PROCEDURE:

1. Case Managers must consult with the Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP) and Core Services Director after consultation with their agency supervisor regarding circumstances leading to potential Statewide Services closure. Discussions may also include other parties such as the Director of HIV Case Management, Quality Service Manager (QSM), Regional Case Management supervisor, etc., as appropriate. A closure determination will include the timeframe for closure and any stipulated requirements that must be met prior to readmission.
2. Case Managers must document all activities leading to the decision for removal or closure in the "Progress Note" in the electronic client database.
3. The ADAP and Core Services Director must notify the client in writing that they have been closed to Statewide Services for reasons other than client request or failure to complete their Annual Update. The letter must include the reason for closure, timeframe for closure, and any stipulated requirements that must be met prior to readmission. (Written notification of

the closure may also come from the Director of HIV Case Management or QSM, etc., as appropriate.)

   a. A detailed breakdown of all services that were provided and their corresponding dollar amounts must be included in fraud-related closure letters.

4. A closure letter specific to Statewide Services must be sent to the client unless a client is also being closed to MO HIV Case Management. (HIV Case Management closure letters should include language that indicates the client will not have access to any RW services once they are closed to HIV Case Management.)
5. Case Managers must coordinate the receipt of the closure notification letter for clients who are unable to receive mail.
6. Case Managers must document conversations with the client about the closure in the "Progress Note" section of the closure encounter. (HIV Case Management Manual Section 7.0)
7. The Case Manager, DHSS, agency supervisor, regional supervisor, or QSM must upload a copy of the closure letter into the "Documents" module of the electronic client database and notify the DHSS Benefits Administrator by submitting a referral made to Healthcare Strategic Initiatives (HSI) in "2SRR." A "Progress Note" outlining the reason for closure must be included under the service referral.
8. The DHSS Benefits Administrator must change the status of the client's service referrals from an "8ENR" to "7CLS" upon removal or closure from Statewide Services. Case Managers will be responsible for closing the HIV Case Management referral, as needed. (HIV Case Management Manual Section 7.0)
9. The DHSS Benefits Administrator will ensure that all relevant service providers are notified that the client has been removed or closed out of Statewide Services.

DOCUMENTATION:

1. Client removal letter
2. Statewide Services Complaint, Grievance, and Appeal Policy
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to provide a consistent mechanism for clients to object to or appeal decisions regarding Statewide Services.

POLICY:

1. Clients have a right to participate in grievance procedures when they believe their rights have been violated.
2. Statewide Services follow the MO HIV Case Management system's policies and procedures when a client has a complaint, grievance, or wishes to appeal a decision. (HIV Case Management Manual Section 2.0)

PROCEDURE:

1. Case Managers must refer to the current Complaint, Grievance, and Appeal Policy and Procedure of the HIV Case Management Manual Section 2.0.
2. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. All documentation required for the Complaint, Grievance, and Appeal Policy and Procedures as indicated in the current HIV Case Management Manual Section 2.0.

SUMMARY:

The following policies and procedures have been established to guide Case Managers through State and Federal RW Program expectations for client pursuit and utilization of other available payment sources for their HIV related services.

POLICY:

1. Statewide Services cannot be utilized to make payments for any item or service for which payment has already been made or can reasonably be expected to be made.
2. Clients must enroll in or utilize all other available resources, before accessing Statewide Services. (This includes vigorous pursuit of Medicaid, Children's Health Insurance Program (CHIP), Medicare, other state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance, etc.)
3. Clients who refuse to enroll in or utilize other available resources may be subject to the loss of Statewide Services or they may be placed on a waiting list for access to Statewide Services.
4. Clients who experience difficulties with other payer source application processes or other systems issues must report them immediately to their Case Manager.
5. DHSS may request additional information or documentation regarding all other available resources at any time during the initial service request, during re-enrollment, or at any time during the client's enrollment in Statewide Services or they may ask the DHSS Benefits Administrator to request additional information.

PROCEDURE:

1. Case Managers must inform clients that they are expected to utilize all other available resources when they become available.
2. Case Managers must inform clients that they are expected to follow through with application and documentation requirements for all other potential payer sources.
3. Case Managers must inform clients that they are expected to follow all other payer source policies in order to maintain their eligibility in the other payer source's program(s), if they become enrolled.
4. Case Managers must upload all documentation related to other payer source application,

approval, or denial in the "Documents" module in the electronic client database:

a. during the client's Annual HIV Case Management update;
b. during the client's six-month HIV Case Management check-in, as applicable;
c. when changes in income, residency, health coverage status, etc. occur; and/or
d. upon request by DHSS or the DHSS Benefits Administrator.

5. Case Managers must document identified issues with other payer source eligibility in the "Progress Note" in the electronic client database.
6. Case Managers must alert the ADAP and Core Services Director and DHSS Benefits Administrator of identified barriers regarding other payer source enrollment via the electronic client database to prevent potential delays in client access to Statewide Services. Barriers may include client's temporary incarceration/institutionalization, health related situations such as hospitalization, applications not showing up in systems yet, etc.

DOCUMENTATION:

1. Other payer source application(s)
2. Other payer source approval letter(s)
3. Other payer source denial letter(s)
4. Other payer source notification(s)
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Veterans of the United States armed forces and Native American or Alaskan Natives may be eligible for a broad range of programs and services provided by the United States Department of Veterans Affairs (VA) or the Indian Health Services (IHS). The following policies and procedures have been established to guide Case Managers through the required steps for requesting or establishing Statewide Services in accordance with Federal mandates.

POLICY:

1. Clients who are veterans of the United States military, American Indian, or Alaskan Native will be held to the same programmatic eligibility requirements, expectations, and limitations as any other Statewide Services clients.
2. Clients who are veterans of the United States military, American Indian, or Alaskan Native have access to services through VA or IHS. However, clients may not be refused access to RW services even though RW is payer of last resort.
3. Clients will be allowed to remain enrolled in Statewide Services during transitions to VA or IHS services, as needed.
4. Clients who wish to utilize VA or IHS for their medical care or prescription medication(s) and who have been assessed a co-payment based on a sliding-scale fee schedule may also qualify for co-payment assistance through Statewide Services, if the provider or pharmacy will accept third-party payment from the DHSS Benefits Administrator.
5. Clients must facilitate and collect information pertaining to third-party payments between the VA or IHS provider, pharmacy, and the DHSS Benefits Administrator and submit all relevant documentation to their Case Manager.

PROCEDURE:

1. Case Managers must inform HIV positive veterans, American Indians, or Alaskan Natives of available services and physical locations of any VA or IHS facilities or programs in their area of residence, etc. as applicable.
2. Case Managers may assist clients in reviewing available VA or IHS Services by accessing the following websites:

a. VA - Home - VA/Department of Defense (DoD) eBenefits

b. IHS - Indian Health Service

3. Case Managers must assist clients who wish to transition from a Statewide Services provider or a health insurance provider to a VA or IHS provider to ensure coordination of care. (This may include assisting clients with the completion of required paperwork, making telephone calls on the client's behalf, etc.)
4. Case Managers must assist clients in facilitating coordination of VA or IHS Services and third-party payments between the client's medical provider, pharmacy, and the DHSS Benefits Administrator, if applicable.
5. Case Managers must upload all relevant documentation regarding VA or IHS Services, into the "Documents" module in the electronic client database, as applicable.

DOCUMENTATION:

1. VA or IHS eligibility determination(s)
2. VA or IHS enrollment documentation
3. VA or IHS summaries of benefits
4. VA or IHS billing statements or fee schedules
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The MO HealthNet (MHN) Program(s) covers qualified medical expenses for individuals who meet certain eligibility requirements. The following policies and procedures have been established for Case Managers to help guide RW clients through the requirements for applying for MHN Program(s) to ensure that RW funds are used as payer of last resort.

POLICY:

1. Clients must be assessed for all MHN Program eligibility including all Fee for Service Programs and Managed Care (expanded MHN) Programs. The assessment must be done at minimum:
    a. within 30-days of enrollment in Statewide Services Program(s);
    b. at the time of the client's six-month check-in if there are changes in insurance coverage, income, disability status or a loss of assets which may qualify them for MHN Program(s); and
    c. at the time of the client's Annual Update.
2. Clients must apply for MHN Program(s) or be assessed for MHN Program(s) eligibility by using the optional Missouri Medicaid Screening Tool. (Appendix A1).
3. DHSS will allow Case Managers the option to assess client eligibility for MHN Program(s) based on the completion of the screening tool if the Case Manager is willing to attest to the validity of the client's responses. Case Managers should consult MHN eligibility criteria for more information.
4. Clients who may become eligible for MHN Program(s) between updates due to health, or other qualifying events such as a reduction in income or assets, etc. must apply for MHN Program(s) immediately.
5. Clients who have attested to no changes in insurance coverage, income, disability status, or a loss of assets at their six-month check-in, do not need to reapply for MHN or complete the optional Missouri Medicaid Screening Tool, until their next Annual Update. (Appendix A1)
6. Clients who would likely qualify for MHN Program(s) must apply for services regardless of other health coverage enrollment (i.e., ADAP/Health Insurance Continuation Program (HICP) approved Affordable Care Act (ACA) Marketplace plans, Medicare, etc.).
7. Clients may need to cancel other existing health insurance policies once their MHN

enrollment becomes active, to avoid potential issues with MHN covering services as the primary payer.

8. If the client does cancel the health insurance policy and the premium payment has been made by the HICP, any refunds sent to the client from the insurer for premiums, must be returned to the RWP immediately upon receipt.
9. Clients who apply for MHN Program(s) must follow-through with all required MHN Medical Review Team (MRT) processes as required. This includes all MHN requirements to apply for the Social Security Disability Program (SSD).
10. Clients may be required to submit MHN Program application(s) upon DHSS request.
11. Clients who have health insurance, but who qualify for MHN Program(s) should consult MHN policies for the Health Insurance Premium Payment Plan (HIPP) and follow their guidance for HIPP enrollment.
12. ACA premium payments will no longer be made once the client's MHN becomes active. (i.e., SWS won't continue to pay premiums for a policy while the client is waiting to become active with HIPP.)
13. Clients who would likely qualify for MHN Program(s) but refuse to apply will not be enrolled in the Statewide Services HICP. The client may be enrolled in the ADAP Uninsured program if they qualify for services.
14. Clients who would likely qualify for MHN Program(s) but fail to follow through with the MHN application(s) will not be enrolled in the Statewide Services HICP. The client may be enrolled in the ADAP Uninsured program if they qualify for services.
15. Clients who reapply to MHN after being denied for failing to follow through with the MHN application will not be enrolled in HICP unless or until they have officially denied enrollment for reasons other than "failure to cooperate", "failure to follow-through" or "failure to provide required documentation". The client will remain enrolled in the ADAP Uninsured program if they qualify for services.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.

2. Case Managers must document when clients have attested to no changes in insurance coverage, assets, income, or disability status between the initial Statewide Service(s) enrollment, at each subsequent six-month check-in, or Annual Update.
3. Case Managers may use the optional Missouri Medicaid Screening Tool to screen/assess clients for MHN. (Appendix A1)
4. Case Managers must consult the MHN Program(s) guidelines for specific eligibility considerations, required documentation, and current versions of the MHN application (online or hard copy forms) to assist clients who would likely qualify for the MHN Program(s).
5. Case Managers must follow-up on application status with their clients until MHN Program(s) eligibility determination(s) are made, when possible.
6. Case Managers must notify the ADAP and Core Services Director via the electronic client database if they become aware that MHN eligibility determination(s) have been delayed due to systemic issues.
7. Case Managers must thoroughly document any identified issues with the MHN Program(s) application processes in the "Progress Note" in the electronic client database and alert DHSS and the DHSS Benefits Administrator when barriers occur (e.g., closest MHN office was closed for an extended period of time, the MHN application is not on file, the client couldn't get the documents needed for the application, etc.). (HIV Case Management Data Rules)
8. Case Managers must upload the optional Missouri Medicaid Screening Tool into the "Documents" module in the electronic client database using the "Missouri MHN Screening Tool" document type. (Appendix A1)
9. Case Managers must upload all other relevant MHN Program(s) eligibility determinations into the "Documents" module in the electronic client database. (HIV Case Management Data Rules)
10. Case Managers must follow current ADAP and HICP Missed or Declined Health Insurance Policies and Procedures for clients who would likely qualify for the MHN Program(s) but refuse to apply. (Subsection 5.4)
11. The DHSS Benefits Administrator will enter the "MA TERM – MHN Termed for Lack of Follow Up" from the drop-down in the Health Coverage Information section of the "Health Coverage" module to indicate when a client's MHN application or coverage has been termed or denied due to lack of follow-through. However, if the client's Case Manager knows the

denial has occurred before HSI becomes aware of it, the Case Manager should enter the information.

12. The "MA TERM – MHN Termed for Lack of Follow Up" entry should be used in addition to the "RW NOINS – No Healthcare Coverage" entry in the "Health Coverage" module in the electronic client database.
13. Case Managers must document the client's loss of MHN in a "Progress Note" and upload all available supporting documentation into the "Documents" module as soon as they become aware of the denial. Examples of supporting documentation may include termination letters from the Department of Social Services (DSS), information obtained from the client's "My DSS" portal, etc. Verbal verification from DHSS or information obtained from eMOMED and the DHSS Benefits Administrator may also serve as verification to include in the "Progress Note".
14. The ADAP and Core Services Director or DHSS Benefits Administrator will monitor for MHN program applications and potential eligibility.
15. The ADAP and Core Services Director or DHSS Benefits Administrator may request additional follow-up if the client's health situation or a reduction in income or assets warrant investigation.

DOCUMENTATION:

1. Optional Missouri Medicaid Screening Tool, if applicable (Appendix A1)
2. Completed MHN application, if applicable
3. MHN Program(s) eligibility determination
4. ADAP and HICP Affidavit of Missed or Declined Health Insurance form, if applicable (Appendix A2)
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The Medicare Part D Low Income Subsidy (LIS) (also called Extra Help) Programs help people with limited income and resources pay for their Medicare premiums and prescription drug costs. The following policies and procedures have been established to guide Case Managers through the steps for assisting Medicare-eligible clients with enrolling in appropriate Medicare programs and as a way to ensure RW Program funds are used as payer of last resort.

POLICY:

1. Clients who are enrolled in Medicare Part A and B are expected to pursue prescription drug coverage through Medicare Part C Advantage Plans or Medicare Part D Prescription Drug plans during Medicare Open Enrollment, (October 15 – December 7 of each calendar year) or during Medicare Special Enrollment Periods if eligible.
2. Clients who are considered dual eligible with Medicare and MHN and who are enrolled in the LIS/Extra Help Program must maintain their dual eligible status when possible.
3. Clients must follow through with Medicare program(s) re-application processes as needed.
4. Clients must enroll in available Medicare program(s) within 30 days of when they first become eligible according to Medicare guidelines.
5. Clients are expected to pursue LIS/Extra Help enrollment at any time during the calendar year. (The LIS/Extra Help Program does not have a specific Open Enrollment date requirement.)
6. A "Medicare Low Income Subsidy" entry located in the client's "Income" module of the electronic client database must be completed for all clients who are known to be receiving LIS/Extra Help from Medicare. (Appendix C1)

PROCEDURE:

1. Case Managers must remind eligible clients of Medicare Part D re-enrollment activities and requirements, which happen during September, November, and December of each calendar year.

2. Case Managers must follow up with clients who are eligible for Medicare to see if they have received communication from Medicare about their current Medicare Part D plan enrollment and assist them with follow-up as needed.
3. Case Managers must assist clients who are eligible for Medicare with comparing Medicare Part D plans or refer the client to a Medicare enrollment specialist beginning October 1, of each calendar year, if needed.
4. Medicare Part D insurance plans supported by HICP must include at minimum, at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral (ARVs) medicines as outlined in the U.S. Department of Health and Human Services (HHS) Clinical Guidelines for the Treatment of HIV.
5. Case Managers must remind clients who are planning to keep an existing Medicare Part D plan that the plan may have changed.
6. The DHSS Benefits Administrator must re-evaluate the Medicare Part D plan to ensure that the plan meets the client's health care needs if requesting HICP assistance.
7. Case Managers must assist clients in enrolling in all available Medicare Programs or refer the client to a Medicare enrollment specialist within 30-days of when a client first becomes eligible according to Medicare guidelines.
8. Case Managers should counsel clients on choosing the Medicare Part D plan that best fits the client's HIV medication coverage needs, as needed if referring to a Medicare enrollment specialist. Medicare Open Enrollment begins October 15 and ends December 7 of each calendar year.
9. Case Managers must assist clients in pursuing the LIS/Extra Help enrollment at any time during the calendar year, as applicable.
10. Case Managers must upload all Medicare-related documentation into the "Documents" module in the electronic client database.
11. DHSS will complete the "Medicare Low Income Subsidy" entry located in the "Income" module of the electronic client database quarterly. However, Case Managers must complete the "Medicare Low Income Subsidy" entry for clients when they are aware of clients who are receiving extra help from Medicare. (Appendix C1)

DOCUMENTATION:

1. Medicare D, Extra Help or LIS Program eligibility determinations
2. Medicare D, Extra Help or LIS Program enrollment documentation
3. Medicare D, Extra Help or LIS Program summaries of benefits
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Ryan White Legislation mandates that funds must be used as payer of last resort and that all other payment sources must be vigorously pursued. The following policies and procedures have been established to guide Case Managers through the required steps for requesting or establishing services for clients who refuse to utilize other payer sources.

POLICY:

1. Clients who request access to Statewide Services, including ADAP or HICP, are expected to vigorously pursue all other available payer sources during the next available opportunity. This includes the pursuit of employer-sponsored policies, ACA Marketplace policies, public policies (Medicare, MHN, etc.). This may be done through Special Enrollment Periods (SEP), or during the next available Open Enrollment period, etc.
2. Clients must obtain written documentation of missed opportunities for employer-sponsored health coverage by submitting a completed and signed HSI Employer Insurance Verification Form. (Appendix A5)
3. Clients may request an exception for the requirement of submitting an HSI Employer Insurance Verification Form, if they are able to provide documentation such as Summary of Benefits, Employer Open Enrollment dates, etc. through other verifiable means, if the requirement creates a conflict of confidentiality for the client. Examples of "other verifiable means" includes pages printed or electronically submitted from client's on-line employer portal, employer supplied documents, either electronic or printed materials. (Appendix A5)
4. Clients who miss or decline opportunities to access other available payer sources for health insurance costs must be informed of the consequences of doing so. (Appendix A2)
5. Clients who have chosen to miss or decline opportunities to access other available payer sources for health insurance costs must complete and sign an ADAP and HICP Affidavit of Missed or Declined Health Insurance Form before becoming enrolled in ADAP or HICP, and during each Annual Update regardless of the reason. (Appendix A2)
6. Clients who have chosen to miss or decline opportunities to access other available payer sources for health insurance costs will be enrolled in the ADAP Uninsured program until they are able to become enrolled with alternative payer source for their health coverage.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must inform all clients requesting medication assistance through the ADAP Uninsured program that ADAP does not provide minimum essential coverage for healthcare and is not considered an insurance plan.
3. Case Managers must inform all uninsured clients requesting assistance through the ADAP Uninsured program that health care providers may refuse to provide them with expected health care services due to their lack of health insurance coverage. (e.g., outpatient ambulatory care is offered by the appropriate RW Grantee and does not provide payment for the same level of services that comprehensive health insurance does.)
4. Case Managers must inform all clients requesting assistance through ADAP or HICP that if they choose not to enroll in other available health insurance coverage, it may increase the likelihood that they could be placed on an ADAP or HICP waiting lists, or that they could lose their ADAP or HICP assistance if funding decreases or is no longer available.
5. Case Managers must insert an Exception Request under the ADAP or HICP service referral for clients who choose not to access health insurance through other available payer sources. The Exception Request must explain or describe the reason(s) the client chose to miss or decline other available payer sources. (Section 9.0)
6. Case Managers are not required to complete an Exception Request for clients who miss health insurance opportunities through no fault of their own such as timing, systemic issues, etc.
7. Case Managers must obtain a completed and signed HSI Employer Insurance Verification Form or other relevant employer health coverage information from clients who miss opportunities for employer-sponsored health coverage and upload it into the “Documents” module in the electronic client database. (Appendix A5)
8. Case Managers must upload a completed and signed copy of the current ADAP and HICP Affidavit of Missed or Declined Health Insurance Form into the “Documents” module in the electronic client database for all clients who have chosen to miss or decline other available payer sources.

9. Case Managers must upload all documentation to support the Exception Request for missed or declined health insurance into the "Documents" module in the electronic client database.

DOCUMENTATION:

1. ADAP and HICP Affidavit of Missed or Declined Health Insurance Form (Appendix A2)
2. Exception Request Narrative clipping, if applicable
3. HSI Employer Insurance Verification Form, if applicable (Appendix A5)
4. Supporting documentation (i.e., special enrollment period information, employer-sponsored open enrollment information, insurance policy information, etc.)
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to inform and guide Case Managers through the required steps for sliding fee scales and the schedule of charges for Statewide Services in accordance with Federal mandates.

POLICY:

1. Statewide Services clients will be responsible for a yearly sliding fee based on their annual family income and size according to federal RW Program requirements.
2. Statewide Services will maintain a sliding fee scale and schedule of charges based on annual FPL guidelines.
3. Statewide Services will not impose a fee for clients with an income less than or equal to 100 percent (%) of the FPL.
4. Statewide Services will impose a fee for clients with an income between 101% and 300% of the current FPL.
5. Client fees are subject to change based on changes in family size and income.
6. The most recent income change will be used for determining the sliding amount.
7. Clients must submit their sliding fee payments directly to the DHSS Benefits Administrator in the form of a check or money order. Case Managers **must not** accept payments from clients.
8. Statewide Services clients **will not** be denied HIV-related treatment or care due to their inability to pay their assigned sliding fee and/or cap on charges.
9. Statewide Services will make the sliding fee scale, limits, or cap on charges available to the public.
10. Clients must mail the annual sliding fee payment to the DHSS Benefits Administrator by January 31 for the prior calendar year.
11. Clients with an annual income of 101% to 200% of FPL shall have an annual cap of charges that shall not exceed five (5) % of their annual gross income.
12. Clients with an annual income of 201% to 300% of FPL shall have an annual cap of charges that shall not exceed seven (7) % of their annual gross income.

SLIDING FEE SCHEDULE:

Household Income	Sliding Fee Per Year
< than 100% of FPL	None
101% to 200% of FPL	$1.00
201% to 300% of FPL	$2.00

PROCEDURE:

1. Case Managers must advise clients of the sliding fee requirement upon initial enrollment and at the client's Annual Update.
2. Case Managers may use the RW Part B and Statewide Services Program Sliding Fee Fact Sheet to discuss the amount the client(s) will be charged each calendar year. (Appendix B3)
3. Case Managers must give the client a copy of the RW Part B and Statewide Services Sliding Scale Fee Fact Sheet at the time of enrollment and at the client's Annual Update. (Appendix B3)
4. DHSS will mail clients a sliding fee reminder letter during December of each year.
5. The December reminder letter will include a payment invoice, RW Part B and Statewide Services Program Sliding Fee Fact Sheet, which includes the FPL Chart. (Appendix B3)

DOCUMENTATION:

1. RW Part B and Statewide Services Program Sliding Scale Fee Fact Sheet (Appendix B3)
2. Client Sliding Fee Reminder Letter (Generated by DHSS)
3. Client Sliding Fee Invoice (Generated by DHSS)

SUMMARY:

The ADAP Uninsured program provides FDA approved medications to low-income people living with HIV who have limited or no health coverage. The following policies and procedures have been established to guide Case Managers through the required steps for requesting or establishing ADAP Uninsured program assistance in accordance with State and Federal mandates.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria. (HIV Case Management Manual Section 3.0)
2. The ADAP Uninsured program cannot pay for any item or service to the extent that for which payment has been made or can reasonably be expected to be made by another payer source, including reimbursement for full or co-payment costs of medications to the client.
3. The ADAP Uninsured program maintains a limited formulary of FDA approved medications.
4. The ADAP Uninsured program will generally not cover non-formulary medications. (Subsection 9.4)
5. Clients must generally be uninsured or unable to obtain cost-effective health insurance coverage, which meet minimum essential coverage standards as defined by the ACA; or which do not provide access to HIV treatment according to the current National Institutes of Health (NIH) guidelines.
6. Clients must pursue and utilize all other available public or private health coverage such as MHN, Medicare, employer-sponsored plans; private health insurance, (i.e., ACA health insurance plans, etc.) within 30-days of ADAP enrollment, or during the next available Open Enrollment opportunity, if eligible.
7. Clients who would likely qualify for public health coverage or who have access to private health insurance, but miss or decline to take the health coverage, must follow current ADAP and HICP Missed or Declined Health Insurance Policies and Procedures. (Subsection 5.4. and Appendix A2)
8. ADAP referrals must be in “8ENR” status when services are rendered, if requesting ADAP assistance.

9. An Exception Request may be entered in the electronic client database for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. Delays may include the client being unable to obtain and submit required eligibility documentation, processing timeframes of Statewide Services referrals, etc. There is no guarantee the Exception Request will be approved. (Section 9.0)

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must upload all MO HIV Case Management eligibility documentation into the "Documents" module in the electronic client database prior to requesting ADAP Uninsured program services. (HIV Case Management Data Rules)
3. Case Managers must insert a new "HSI – ADAP Program/Medications" service referral in "1RFR" status. (HIV Case Management Data Rules)
4. If the client already has a service referral that is in "8ENR" status, adding a new referral is not necessary.
5. Case Managers must obtain approval from the appropriate RW Grantee in order for the client to receive ambulatory/outpatient care assistance.
6. Case Managers should check with their supervisors to verify the appropriate way to request ambulatory/outpatient medical care assistance.
7. Case Managers must enter all health insurance coverage information in the "Health Coverage" module of the electronic client database. (HIV Case Management Data Rules)
8. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added.
9. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
10. The DHSS Benefits Administrator will change the service referral status to "8ENR" if approved.
11. Case Managers must submit an Exception Request in the electronic client database for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. (Section 9.0)

12. Case Managers must ensure that all clients who would likely qualify for MHN apply for MHN within 30-days of initial enrollment into the ADAP Uninsured program. (Subsection 5.2)

DOCUMENTATION:

1. Optional Missouri Medicaid Screening Tool, if applicable (Appendix A1)
2. Completed MHN Program(s) application, if applicable
3. MHN Program(s) eligibility determination
4. Private insurance member card, if applicable
5. ADAP and HICP Affidavit of Missed or Declined Health Insurance form, if applicable (Appendix A2)
6. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

HICP is intended to assist with health insurance related costs including prescription and healthcare co-payments, as well as premiums, deductibles, out-of-pocket maximums, and co-insurance for eligible clients. The following policies and procedures have been established to guide Case Managers through the required steps for requesting or establishing HICP assistance in accordance with State and Federal mandates.

POLICY:

1. Clients meet the minimum MO HIV Case Management eligibility criteria in order to qualify for HICP services. (HIV Case Management Manual Section 3.0)
2. Clients must be eligible to or already enrolled in health insurance to qualify for HICP services.
3. HICP services are based on funding availability.
4. HICP cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. Health insurance plans supported by HICP must include at least one FDA-approved medicine in each drug class of core ARV medicines as outlined in the HHS Clinical Guidelines for the Treatment of HIV.
6. Health insurance plans supported by HICP must include appropriate HIV outpatient ambulatory care services.
7. Health insurance plans supported by HICP must be cost-effective. This means the cost of paying for health care coverage (including all other sources of premium and cost-sharing assistance) must be less expensive than paying for the full cost of medications and appropriate HIV outpatient ambulatory care.
8. Before enrollment in HICP, all health insurance plans must be reviewed by the DHSS Benefits Administrator for cost-effectiveness and minimum essential coverage, including access to ARVs and healthcare providers. Additional review is not necessary if a client is enrolling in a HICP-approved ACA plan. DHSS and the DHSS Benefits Administrator will conduct the review prior to the client's enrollment in the ACA plan.

9. Health insurers and health care providers must accept third-party payment in order for clients to receive HICP premium or medical care co-payment assistance.
10. HICP will not cover dental riders unless they are included in an employer-sponsored plan package and cannot be removed from the health insurance premium amount.
11. HICP will not generally cover family health insurance plans unless electing the family plan is an ACA Marketplace requirement for coverage.
12. HICP may not cover co-payment for services listed on the Ryan White (RW) Part B/AIDS Drug Assistance Program (ADAP) Health Insurance Continuation Program (HICP) Limitations and Exclusions. (Appendix C5)
13. Statewide Services referrals must be in "8ENR" status when services are rendered if requesting assistance.
14. Clients must utilize all other available sources of premium and cost-sharing assistance to ensure RW remains the payer of last resort. This includes accessing public health coverage such as MHN, Medicare, employer-sponsored plans, and private health insurance, including ACA/Marketplace health insurance plans.
15. Clients must generally work within networks and limitations of the HICP-approved health insurance plan benefits.
16. Clients will not be eligible for continued health insurance assistance once they reach their health insurance plan coverage caps or limitations.
17. Clients who would likely qualify for public health coverage or have access to private health insurance but who miss or decline to take it must follow current ADAP and HICP Missed or Declined Health Insurance Policies and Procedures. (Subsection 5.4 and 7.2, Appendix A2)
18. An Exception Request may be submitted to the DHSS Benefits Administrator for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. (Examples of delays may include the client's ability to obtain and submit required eligibility documentation, delays in processing Statewide Services referrals, etc.) There is no guarantee the Exception Request will be approved. (Section 9.0)

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.

2. Case Managers must upload all MO HIV Case Management eligibility documentation into the electronic client database "Documents" module before requesting HICP services. (HIV Case Management Data Rules)
3. Case Managers must insert a new "HSI – Health Insurance Continuation" service referral in "1RFR" status. (HIV Case Management Data Rules)
4. Case Managers must insert new "HSI – Ambulatory/Outpatient Medical Care Co-Pays" and "HSI – ADAP Program/Medications" service referrals in "1RFR" status.
5. If the client already has a service referral that is in "8ENR" status for any of these services, adding a new referral is not necessary.
6. Case Managers must upload all relevant health insurance plan documentation into the "Documents" module in the electronic client database and alert the DHSS Benefits Administrator via electronic client database communicate when the documentation is ready for review.
7. Case Managers must upload a completed copy of the HSI Care Services HICP Release Form into the "Documents" module in the electronic client database before entering the service referrals. (Appendix A6)
8. Case Managers must enter all health insurance information in the "Health Coverage" module at the time of the HICP service referral request. (HIV Case Management Data Rules)
9. The DHSS Benefits Administrator will review the documentation to ensure that the plan is cost-effective for HICP and meets the ACA minimum essential benefit coverage requirements.
10. The DHSS Benefits Administrator will review the "Documents" module in the electronic client database to ensure that required documentation has been appropriately added.
11. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
12. The DHSS Benefits Administrator will change the service referral status to "8ENR" if approved.
13. Case Managers must submit an Exception Request for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. (Section 9.0 and Appendix C1)

14. The DHSS Benefits Administrator will follow up with the ADAP and Core Services Director as needed.
15. The DHSS Benefits Administrator will notify the Case Manager via communicate or by telephone before a health insurance policy is terminated or when there are issues with premiums, co-payments, etc., when possible.

DOCUMENTATION:

1. Health insurance plan information including:
    a. payment cost documentation,
    b. health insurance plan formulary,
    c. health insurance Summary of Benefits, and
    d. billing information, etc.
2. HSI Care Services HICP Release Form (Appendix A6)
3. Optional Missouri Medicaid Screening Tool, if applicable (Appendix A1)
4. Completed MHN, PWD Program application, if applicable
5. MHN, PWD Program eligibility determination, if applicable
6. Private health insurance member card
7. ADAP and HICP Affidavit of Missed or Declined Health Insurance Form, if applicable (Appendix A2)
8. Other documentation, as requested by DHSS or the DHSS Benefits Administrator
9.

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for establishing HICP assistance for clients who have private health insurance policies, in accordance with State and Federal mandates.

POLICY:

1. Clients must be insured and meet the minimum MO HIV Case Management eligibility criteria in order to qualify for HICP Services. (HIV Case Management Manual Section 3.0)
2. HICP cannot pay for any item or services for which payment has been made or can reasonably be expected to be made by another payer source.
3. Private health insurance plans supported by HICP must include at minimum, at least one FDA approved medicine in each drug class of core ARV medicines as outlined in the HHS Clinical Guidelines for the Treatment of HIV.
4. Private health insurance plans supported by HICP must include appropriate HIV outpatient ambulatory care services.
5. Private health insurance plans supported by HICP must be cost-effective. This means the cost of paying for the health care coverage (including all other sources of premium and cost-sharing assistance) must be less expensive than paying for the full cost of medications and appropriate HIV outpatient ambulatory care services.
6. Private health insurance plans must be reviewed by the DHSS Benefits Administrator for cost-effectiveness and minimum essential coverage, including access to ARVs and healthcare providers before enrollment in HICP. Additional review is not necessary if a client is enrolling in a HICP approved ACA Marketplace plan, because DHSS and the DHSS Benefits Administrator will conduct the review prior to the client's enrollment into the ACA plan.
7. Health insurers and healthcare providers must accept third-party payment in order for clients to receive HICP premium and medical care co-payment assistance.
8. HICP will not cover dental riders unless they are included as part of an employer-sponsored plan package and cannot be removed from the health insurance premium amount.
9. HICP may not cover co-payment for services listed on the Ryan White (RW) Part B/AIDS Drug Assistance Program (ADAP) Health Insurance Continuation Program (HICP) Limitations and Exclusion. (Appendix C5)

10. HICP services are based on funding availability.
11. HICP referrals must be in an "8ENR" status at the time premium, and copayment costs are incurred, if requesting HICP assistance.
12. Clients must utilize all other available sources of premium and cost-sharing assistance to ensure RW remains the payer of last resort. This includes accessing public health coverage such as MHN, Medicare, employer-sponsored plans, private health insurance, including ACA health insurance plans, etc.
13. Clients must generally work within the networks and limitations of the HICP approved health insurance plan benefits.
14. Clients will not be eligible for co-payment assistance once they reach their health insurance plan coverage caps or limitations.
15. Clients who would likely qualify for public health coverage or have access to private health insurance but who miss or decline to take it must follow current ADAP and Missed or Declined Health Insurance policies and procedures. (Subsection 5.4.)
16. Clients who choose to miss or decline health insurance coverage from another payer source will not be eligible for HICP; however, they may be enrolled in the ADAP Uninsured program if they otherwise qualify for services.
17. Clients who do not have other private health insurance and who are eligible for a health insurance plan through the ACA Marketplace must enroll in an HICP approved plan, if requesting assistance with their premium payments.
18. Clients must work with their Case Manager, etc. to become enrolled in a HICP approved plan.
19. HICP will not provide assistance for an ACA Marketplace plan that has not been HICP reviewed and approved.
20. Clients who qualify for a SEP in the months of October through December will be eligible for the ADAP Uninsured program until they qualify for public insurance (e.g. MHN, Medicare, etc.) or private insurance (e.g. employer sponsored, ACA, etc.). Clients should not seek a SEP in these circumstances and should enroll in an eligible ACA plan during the next available open enrollment.
21. Clients who are experiencing a catastrophic or extraordinary medical circumstance, (cancer/co-condition, etc.) which would require prescription coverage beyond services

covered by the ADAP Uninsured program and the ambulatory care assistance provided by the appropriate RW Grantee, may request an exception to enroll in COBRA and/or apply for a SEP for an eligible ACA plan during the months of October-December.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must upload all MO HIV Case Management eligibility documentation into the "Documents" module in the electronic client services database before requesting HICP services. (HIV Case Management Manual Section 3.0)
3. Case Managers must follow the HICP service referral processes for non-ACA Marketplace health insurance plans. (Appendix C1 and HIV Case Management Data Rules)
4. Case Managers must follow the most current health insurance enrollment processes for ACA Marketplace health insurance plans, including participation in ACA Marketplace Open Enrollment activities and ACA Marketplace SEPs, as instructed by DHSS.
5. DHSS and the DHSS Benefits Administrator will update Open Enrollment processes each Open Enrollment period and alert Case Managers when guidance for ACA Marketplace Open Enrollment activities are finalized.
6. Case Managers may submit an Exception Request on behalf of clients who are experiencing a catastrophic or extraordinary medical circumstance, (cancer/co-condition, etc.) for enrollment into ACA/Marketplace insurance coverage through a SEP or COBRA policy during October – December. (Section 4.0)

DOCUMENTATION:

1. Private health insurance plan information including:
    a. payment cost documentation,
    b. health insurance plan formulary,
    c. health insurance Summary of Benefits, and
    d. billing information
2. HSI Care Services HICP Release Form (Appendix A6)
3. Optional Missouri Medicaid Screening Tool results, if applicable (Appendix A1)
4. Completed MHN application, if applicable

5. MHN eligibility determination, if applicable
6. Private health insurance member card
7. ADAP and HICP Affidavit of Missed or Declined Health Insurance form, if applicable (Appendix A2)
8. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for establishing HICP assistance for clients who have employer-sponsored health insurance policies, in accordance with State and Federal mandates.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for HICP Services. (HIV Case Management Manual Section 3.0)
2. HICP services are based on funding availability.
3. HICP cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
4. HICP may not cover co-payments for services listed on the Ryan White (RW) Part B/AIDS Drug Assistance Program (ADAP) Health Insurance Continuation Program (HICP) Limitations and Exclusions. (Appendix C5)
5. Clients must utilize all other available sources of premium and cost-sharing assistance to ensure RW remains the payer of last resort, including accessing employer-sponsored plans. (Section 5.0)
6. Clients who miss or decline employer-sponsored plans may not be approved for ADAP assistance with an ACA/Marketplace health insurance plan.
7. Clients who are offered an employer-sponsored health insurance plan with a "maximum" amount, called "limited" or discounted, or an employee portion of the premium that is 9.5% of gross income have the option to apply for a HICP-approved ACA Marketplace health insurance plan.
8. Clients must generally work within the boundaries their HICP approved employer-sponsored health insurance plan benefits.
9. Clients will not be eligible for continued co-payment assistance once they reach their employer-sponsored health insurance plan coverage caps or limitations. (e.g., additional co-payments or other services.)
10. Employer-sponsored health insurance plans supported by HICP must include at minimum, at least one FDA approved medication in each drug class of core ARV medicines as outlined in

the HHS Clinical Guidelines for the Treatment of HIV.

11. Employer-sponsored health insurance plans supported by HICP must include appropriate HIV outpatient ambulatory care services.
12. Employer-sponsored health insurance plans supported by HICP must be cost-effective. This means the cost of paying for health care coverage (including all other sources of premium and cost-sharing assistance) must be less expensive than paying for the full cost of medications and appropriate HIV outpatient ambulatory health care services.
13. Clients must pursue employer-sponsored coverage during the employer's regular open enrollment.
14. Clients who qualify for an SEP in the months of October through December will be enrolled in the ADAP Uninsured program for access to ADAP formulary-approved medication if they are eligible for services. Clients should not seek an SEP in these circumstances and should enroll in an eligible ACA/Marketplace health insurance plan during the next available open enrollment.
15. Clients who are experiencing a catastrophic or extraordinary medical circumstance, (cancer/co-condition, etc.) that would require coverage beyond services covered by the ADAP Uninsured program and the ambulatory care assistance provided by the appropriate RW Grantee, may request an exception to enroll in COBRA and/or apply for a SEP for an eligible ACA/Marketplace health insurance plan during the months of October through December. (Section 9.0)
16. The DHSS Benefits Administrator must review all employer-sponsored health insurance plans for cost-effectiveness and minimum essential coverage, including access to ARVs and health care providers prior to enrollment in HICP.
17. The DHSS Benefits Administrator may be able to assist with a client's employer-sponsored health insurance premium payment if the plan is cost-effective, meets the client's HIV health-related needs and if the employer's health insurance provider will accept third-party payment.
18. Clients must submit a completed HSI Employer Insurance Verification Form and a copy of the plan Summary of Benefits to their Case Manager if the client is employed and requests HICP assistance with their employer-sponsored health insurance during the following

(Appendix A5):

a. at the time of initial HICP enrollment;
b. during the next available employer open enrollment period; and
c. when the client changes employment if they wish to continue to receive HICP assistance.

19. Clients who do not have a viable employer-sponsored plan option for HICP coverage will be expected to pursue an ACA/Marketplace health insurance plan at the next available open enrollment or through a SEP between January and September if eligible.
20. Clients who would likely qualify for employer-sponsored health insurance, but who miss or decline to take it, must follow current ADAP and HICP Missed or Declined Health Insurance Policies and Procedures. (Subsection 5.4 and Appendix A2)
21. HICP referrals must be in "8ENR" status at the time premium and copayment costs have been incurred if requesting HICP assistance.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must review the employed client's submitted pay stubs for any type of employer-sponsored insurance, including dental, vision, etc., to ensure that the client has not been offered comprehensive, employer-sponsored health coverage.
3. If the client has missed or declined the coverage for any reason, the Case Manager must follow SWS Policies and Procedures. (Subsection 5.4)
4. The Case Manager must also verify with the client or the client's employer when the next employer open enrollment will occur and include the information in the required Exception Request. (Subsection 5.4)
5. The DHSS Benefits Administrator will include an end date for the "HSI – Health Insurance Continuation" service referral that is 30 days prior to the end of the employer's open enrollment period to ensure the client follows up with enrolling in the employer-sponsored health coverage.
6. Case Managers must provide a blank copy of the HSI Employer Insurance Verification Form to the client if the client requests HICP assistance for employer-sponsored premium

payments. (Appendix A5)

7. Case Managers must upload the completed HSI Employer Insurance Verification Form, the plan Summary of Benefits and all other relevant insurance documentation into the "Documents" module in the electronic client database. (Appendix A5)
8. The DHSS Benefits Administrator will review the HSI Employer Insurance Verification Form and other employer-sponsored health insurance plan information and notify Case Managers of the results of the review. (Appendix A5)
9. The DHSS Benefits Administrator will submit premium payments to the client's employer, if applicable.
10. Case Managers may submit an Exception Request clipping according to the Statewide Services Data Rules on behalf of clients who are experiencing a catastrophic or extraordinary medical circumstance, (cancer/co-condition, etc.) for enrollment into ACA coverage through a SEP or COBRA policy during October – December. (Section 9.0 and Appendix C1)

DOCUMENTATION:

1. HSI Employer Insurance Verification Form (Appendix A5)
2. Employer-sponsored health insurance plan information including:
    a. payment cost documentation,
    b. health insurance plan formulary,
    c. health insurance Summary of Benefits, and
    d. billing information.
3. HSI Care Services HICP Release Form (Appendix A6)
4. Private health insurance member card
5. ADAP and HICP Affidavit of Missed or Declined Health Insurance Form, if applicable (Appendix A2)
6. Client's pay stubs, if applicable
7. Exception Request, if applicable
8. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT POLICY:

1. COBRA policies will not typically be covered by Statewide Services due to the availability of SEPs for ACA/Marketplace health insurance plans.
2. Clients who have lost their employer-sponsored coverage must apply for other available public or private health coverage immediately upon loss of the employer-sponsored health coverage. This may include applying for MHN, Medicare, or an SEP (prior to October 1) for ADAP-approved ACA/Marketplace health insurance plans.
3. Clients who do not qualify for other public health coverage or an ACA/Marketplace SEP will be eligible for enrollment in the ADAP Uninsured program for access to ADAP formulary-approved medication until coverage for an ADAP-approved ACA/Marketplace health insurance plan can begin, if otherwise eligible for Statewide Services.
4. Clients who are experiencing a catastrophic or extraordinary medical circumstance (cancer/co-condition, etc.) that would require coverage beyond services covered by the ADAP Uninsured program and the ambulatory care provided by the appropriate RW Grantee may request to enroll in COBRA coverage until alternative coverage can begin.
5. DHSS or the DHSS Benefits Administrator may request additional documentation regarding a client's catastrophic or extraordinary medical circumstance (cancer/co-condition, etc.) prior to approving coverage of a COBRA policy (e.g., a physician's note explaining why the client's health coverage should be approved, due to detrimental impact on the client's HIV health status, etc.).
6. Clients who have been approved to enroll in a COBRA plan must submit plan information to their Case Manager within five business days due to the limited enrollment period (60 days) to avoid losing the policy.
7. The DHSS Benefits Administrator must review the COBRA policy for cost-effectiveness and minimum essential coverage; including access to ARVs and provider access if the client wants HICP to assist with COBRA premium payments.
8. If the COBRA policy is determined to be insufficient or non-cost effective, the client must enroll in an HICP-approved ACA/Marketplace health insurance plan, etc., during the next health insurance open enrollment or SEP, if eligible.
9. The client will be enrolled in the ADAP Uninsured program for access to ADAP formulary-

approved medication until coverage for an ADAP-approved ACA/Marketplace health insurance plan can begin.

PROCEDURE:

1. Case Managers may submit an Exception Request for HICP assistance to enroll clients in COBRA from October through December on behalf of clients who are experiencing a catastrophic or extraordinary medical circumstance. (Subsection 9.0 and Appendix C1)
2. Case Managers must upload all COBRA health insurance plan documentation and requested health information into the "Documents" module in the electronic client database within seven days of receipt of information due to the limited COBRA enrollment period (60-days).
3. Case Managers must follow general HICP procedures for client enrollment into HICP (Section 7.0)
4. The DHSS Benefits Administrator will review the COBRA health insurance plan information and notify the Case Manager with the results of the review.

DOCUMENTATION:

1. HSI Employer Insurance Verification Form, if applicable (Appendix A5)
2. Exception Request, if applicable.
3. COBRA health insurance plan information including:
    a. payment cost documentation,
    b. health insurance plan formulary,
    c. health insurance Summary of Benefits, and
    d. billing information.
4. HSI Care Services HICP Release Form (Appendix A6)
5. Optional Missouri Medicaid Screening Tool, if applicable (Appendix A1)
6. Completed MHN application, if applicable
7. MHN Program(s) eligibility determination
8. Private insurance member card
9. ADAP and HICP Affidavit of Missed or Declined Health Insurance Form, if applicable (Appendix A2)

10. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Medicare provides health care coverage for those who are aged 65 and older and for individuals who are permanently and totally disabled. Medicare has four parts:

a. Medicare Part A (hospital insurance) covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, and home health care;
b. Medicare Part B (medical insurance) covers doctor and other health care providers' services, outpatient care, durable medical equipment, home health care, and some preventive services;
c. Medicare Part C (Medicare Advantage Plans) provides Medicare Part A and B benefits, and may include prescription drug coverage (Part D); and
d. Medicare Part D Medicare Prescription Drug Coverage covers prescription drugs.

The following policies and procedures have been established to guide Case Managers through the required steps for establishing HICP assistance for Medicare eligible clients in accordance with State and Federal mandates.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for HICP Services. (Case Management Manual Section 3.0)
2. HICP may not cover co-payment for services listed on the Ryan White (RW) Part B/AIDS Drug Assistance Program (ADAP) Health Insurance Continuation Program (HICP) Limitations and Exclusions. (Appendix C5)
3. HICP services are based on funding availability.
4. HICP may assist with Medicare premiums and cost-sharing associated with Medicare Parts B, C, and D coverage, when doing so is determined to be cost-effective versus paying for the full cost of medications.
5. Federal mandates stipulate that HICP must also pay for the Medicare Part D (medication) premiums and cost-sharing in conjunction with Medicare B and C plans, if paying premiums for those Medicare Parts. (Appendix C4)
6. Medicare Parts B and C must include ACA defined minimum essential health benefits coverage for both outpatient and ambulatory health services.

7. Medicare Part D health insurance plans supported by HICP must include at least one FDA approved medicine in each drug class of core ARV medicines as outlined in the HHS Clinical Guidelines for the Treatment of HIV at minimum.
8. HICP cannot be used to pay for premiums or cost-sharing assistance for Medicare Part A because inpatient care is not a RW Program allowable cost.
9. HICP cannot provide assistance with Supplemental Medicare plans (also known as Medigap policies).
10. Clients must utilize all other available sources of premium and cost-sharing assistance to ensure RW remains the payer of last resort. This includes Medicare and MHN programs, such as the LIS/Extra Help, Specified Low-Income Medicare Beneficiary (SLMB) Program and the Qualified Medicare Beneficiary (QMB) Program (Subsection 5.2)
11. Clients must generally work within the networks and limitations of their HICP approved Medicare plan benefits.
12. Clients will not be eligible for continued HICP assistance once they reach their Medicare plan coverage caps or limitations. (i.e., additional co-payments or other services.)
13. Clients who request HICP assistance with Medicare premium payments must coordinate with Social Security to ensure the premium(s) are not taken directly from the client's Social Security check.
14. Clients must submit a Medicare Part B, C or D premium notice which includes the client's premium amount, payee name, remittance address, etc. to their Case Manager so the DHSS Benefits Administrator can make a third-party payment to Social Security on the client's behalf.
15. HICP cannot pay for any item or services for which payment has been made or can reasonably be expected to be made by another payer source. This includes other public assistance payer sources such as QMB or SLMB, or reimbursing clients whose premium has been deducted from the client's Social Security check.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.

2. Case Managers should follow general HICP procedures for client enrollment into HICP for Medicare clients, if the Medicare plan meets Federal requirements for HICP coverage. (Section 7.0 and Appendix C4)

DOCUMENTATION:

1. Medicare health insurance plan information including:
    a. Medicare premium and other cost documentation,
    b. Medicare health insurance plan formulary,
    c. Medicare health insurance Summary of Benefits, and
    d. billing information.
2. HSI Care Services HICP Release Form (Appendix A7)
3. MHN eligibility determinations, if applicable
4. Medicare member card
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Monthly Spenddown and Ticket to Work Health Assurance Program (TWHA) premiums are assigned to some RW clients by MHN based on income and part-time working status. The following policies and procedures have been established to guide Case Managers through the required steps for establishing Statewide Services assistance for these MHN associated costs.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for Spenddown or TWHA assistance. (HIV Case Management Manual Section 3.0)
2. Clients who are eligible for the MHN, PWD Program and who have been assigned a monthly Spenddown payment may receive assistance with payment of their monthly Spenddown to ensure access to home health services, medication, and healthcare.
3. Clients who are enrolled in the MHN, TWHA Program may receive assistance with payment of their monthly TWHA premium payments to ensure access to medication and healthcare.
4. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. TWHA health insurance plans supported by Statewide Services must include at minimum, at least one FDA approved medicine in each drug class of core ARV medicines as outlined in the HHS Clinical Guidelines for the Treatment of HIV.
6. Paying the Spenddown and TWHA premium payments must be cost-effective to the RW Program. This means the cost of paying for the Spenddown or TWHA premium payment must be less expensive than paying for the full cost of medications and appropriate HIV outpatient ambulatory care services.
7. Spenddown and TWHA premium assistance is available as funding permits.
8. Clients who request assistance with Spenddown or TWHA premiums must submit MHN verification of the Spenddown or TWHA premium amount to their Case Manager.

PROCEDURE:

1. Case Managers must obtain and upload MHN verification of the Spenddown or the TWHA premium amount into the “Documents” module in the electronic client database as soon as it

is available.

2. DHSS staff will match MO HIV Case Management enrollment with MHN enrollment 45-days prior to the month of Spenddown payment to verify Spenddown or TWHA status and premium payment amounts.
3. The DHSS Benefits Administrator must issue verified Spenddown and TWHA premium amounts directly to MHN on behalf of eligible clients.
4. Case Managers must send an electronic client database communicate to the DHSS Benefits Administrator to request an individual payment for RW clients who are:
    a. new to having a Spenddown payment;
    b. new to the TWHA Program; and
    c. when a Spenddown or TWHA premium payment has been missed
5. Case Managers must copy the SPPC/AIDS Waiver Benefits Specialist on the electronic client database communicate if the client is also a SPPC/AIDS Waiver client.
6. Case Managers must specify the issue the client is having with their Spenddown or TWHA premium in the subject line of the electronic client database communicate. The communicate must also include the client's DCN, as well as the client's first and last name to ensure timely payment coordination.
7. The DHSS Benefits Administrator will issue payment directly to MHN via individual check if payment is necessary.

DOCUMENTATION:

1. MHN verification of the Spenddown or TWHA premium amount
2. Medicare card, if applicable
3. Other insurance provider information, if applicable

SUMMARY:

The Advanced Premium Tax Credit (APTC) is a federal subsidy available to individuals and families who earn 100%-400% of the FPL. The ACA/Marketplace may have assigned an APTC to some HICP clients who are or were enrolled in an HICP approved health insurance plan, depending on the amount of income reported to Healthcare.gov. The following policies and procedures have been established to ensure compliance with Federal mandates regarding the APTC.

POLICY:

1. Clients must select the option for advance payment of the premium tax credit, when enrolling in ACA Marketplace health insurance coverage.
2. Clients must update their income amount with their Case Manager and with Healthcare.gov when it changes to avoid any variance with the APTC and to avoid acquiring an APTC credit or liability from the Internal Revenue Service (IRS) at the end of the tax year.
3. Clients who receive an APTC for health insurance costs through the Marketplace for an ACA plan must file a Federal income tax return with the IRS to determine the correct amount of APTC for the year. IRS Form 8962 will indicate if they received an APTC for health insurance premium costs. Line 26 of the form will reflect the amount of the refund or tax due.
4. Clients who receive an APTC refund from the IRS must contact their Case Manager immediately to report the amount of the credit or refund as reflected on IRS Form 8962.
5. Clients who receive an APTC refund must arrange payment of the full amount of the APTC refund to the DHSS Benefits Administrator immediately upon receipt of their IRS tax refund. (Clients do not need to submit their entire refund to the DHSS Benefits Administrator, unless the entire amount of the refund is due to the APTC. (Subsection 7.6)

PROCEDURE:

1. Clients must notify the DHSS Benefits Administrator immediately via electronic client services database communicate upon learning that their client's income amount has changed.

This will help ensure that the changed amount can be reported to Healthcare.gov to avoid the client's acquiring an APTC credit or liability from the IRS at the end of the tax year.

2. Case Managers who are notified that a client has received a refund as a result of the APTC must notify the ADAP and Core Services Director via electronic client database communicate, immediately.
3. The ADAP and Core Services Director will alert the client by letter or telephone that they must make arrangements to pay back the total amount of the refund to the DHSS Benefits Administrator immediately upon receipt of their IRS tax refund if the client has had their health insurance premium paid for by HICP.
4. Case Managers must upload all documentation regarding the client's IRS issued APTC tax credits or refunds into the "Documents" module of the electronic client database, if available.
5. Case Managers must use the electronic client database Document type, "X Other (Enter description in Name Field)". The "Name" field must be filled in with "APTC Penalty-Refund Document".

DOCUMENTATION:

1. IRS Form: Attachment 8962
2. Federal IRS Tax Form 1040
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Clients who are or were previously enrolled in Statewide Services may receive refunds addressed to them from various sources for overpayment of any of the following services:

1. APTCs (Subsection 7.5)
2. Health insurance premium payments (Section 7.0)
3. MO HealthNet (Medicaid) Spenddown payments (Subsection 7.4)
4. Medical care deductibles, co-payments, co-insurance
5. Medication deductibles, co-payments, co-insurance, etc. (Subsection 7.0)

The following policies and procedures have been established to inform Case Managers of the required actions that must be taken by clients regarding health insurance related refund payments.

POLICY:

1. Clients who receive a refund check for any service paid for with RW funds must submit the full amount of the refund to the DHSS Benefits Administrator within 30-days of receiving the refund. This includes refunds for co-payments of medication or health care services, which are associated with health insurance premiums. (Section 7.0)
2. Clients who have cashed or deposited a refund check must return the total amount of the refund to the DHSS Benefits Administrator within 30-days of cashing or depositing the refund check.
3. Clients who have cashed a refund check cannot make payments to HSI. They will have their HICP services suspended until full repayment has been made. This includes suspension of any of the following services:
    a. Health insurance premium payments
    b. MHN Spenddown payments
    c. Medical Care deductibles/co-payments/co-insurance
4. Clients who have HICP services suspended may qualify for ADAP medication coverage if they otherwise meet current eligibility criteria. (Section 6.0)

5. The appropriate RW Grantee will be responsible for approving or denying MO HIV Case Management and ambulatory care or other region specific services for clients who have had health insurance services suspended.
6. Clients who have had HICP services suspended due to not paying back a refund and who have repaid the total amount will be expected to pursue health insurance enrollment at the next available opportunity, as applicable.

PROCEDURE:

1. Case Managers must report to the ADAP and Core Services Director when client refunds occur if they become aware that a client has received a refund via the electronic client services database communicate.
2. Case Managers must guide clients through the steps for submitting refunds and inform them of the consequences of not following policy, if requested.

PROCEDURE FOR RETURNING UNCASHED CHECKS:

1. Clients must sign the back of an uncashed refund check and print their name below their signature.
2. Clients must write on the back of the uncashed refund check "Pay to the order of" the DHSS Benefits Administrator. (e.g., Pay to the order of HSI.)
3. Checks that are directly returned to a Case Manager or Case Management agency rather than the client must be returned to the DHSS Benefits Administrator on the client's behalf.
4. Clients must mail the check to the DHSS Benefits Administrator.

PROCEDURES FOR CASHED OR DEPOSITED CHECKS

1. Clients who have cashed a refund check or deposited it in their personal banking account must return the total amount of the refund to the DHSS Benefits Administrator within 30-days via money order or personal check.
2. Clients must address checks or money orders to the DHSS Benefits Administrator.
3. Clients must write their name and the name of the entity that issued the refund in the memo line of the check or money order.

4. Clients must mail personal checks or money orders to the DHSS Benefits Administrator.
5. DHSS staff will track refund payments and coordinate with the DHSS Benefits Administrator to suspend services, when necessary.

SUSPENSION PROCEDURES

1. DHSS staff will notify clients via postal mail 30-days prior to health insurance service suspension.
2. DHSS will alert the appropriate RW Grantee, regional supervisor, Case Manager, regional QSM, DHSS Benefits Administrator, etc. via the electronic client services database communicate prior to sending the client suspension notice.
3. Case Managers must open the appropriate "HSI – Ambulatory/Outpatient Medical Care" and "HSI – ADAP Program/Medications" service referrals in the electronic client services database for individuals who have been suspended from HICP and who wish to be considered for ADAP services as an uninsured client.
4. The appropriate RW Grantee must approve or deny ambulatory costs prior to submitting an "HSI – Ambulatory/Outpatient Medical Care" service referral in the electronic client services database.
5. The ADAP and Core Services Director will review the client's refund repayment situation and approve or deny the "HSI – Ambulatory/Outpatient Medical Care" service referral.
6. Case Managers must document any information they may have about refunds or repayments in the "Progress Note" in the electronic client services database.
7. DHSS staff will track refund payments and coordinate with the appropriate Case Manager and the DHSS Benefits Administrator to re-enroll a client in HICP services, when applicable.

DOCUMENTATION:

1. All refund documentation including, refund check stubs and client letter(s), etc., if available
2. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for establishing assistance for ADAP or HICP eligible clients during temporary gaps in coverage.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for Statewide Service assistance during gaps in coverage. (HIV Case Management Manual Section 3.0).
2. Statewide Services will generally provide coverage of an eligible client's medication through gaps in health insurance coverage or between public assistance eligibility determinations.
3. Statewide Services cannot pay for any item or service for which payment has been made, or can reasonably be expected to be made by another payer source.
4. Statewide Services will not cover medications that are not included on the current ADAP formulary.
5. Statewide Services will consider exception requests for ARVs not currently covered on the ADAP formulary if all other potential payment sources have denied coverage of the ARV. (Subsection 9.4)
6. Clients who have active health insurance coverage must attempt to contact their health insurance provider if they experience issues with their policy to determine how to resolve the coverage issue, if possible.
7. Clients must contact their Case Manager to report issues with their health insurance policy's coverage.

PROCEDURE:

1. Case Managers must review the most current version of the document "HSI Processes for Individuals Who Experience a Gap in Health Insurance Coverage" located in the electronic client database for insured clients who report issues with their ACA Marketplace health insurance coverage. (MO Support Files/Healthcare Coverage)
2. Case Managers must include a detailed description explaining all issues or challenges

associated with the client's coverage gap in the "Progress Note" in the electronic client database.

3. Case Managers must contact the DHSS Benefits Administrator via electronic client database communicate to report issues or challenges associated with the client's coverage gap to determine appropriate follow-up action steps.
4. Case Managers may submit an Exception Request on behalf of clients who request access to ARVs not currently covered on the ADAP formulary. (Section 9.0)
5. Case Managers must upload all supporting documentation related to the coverage gap in the "Documents" module in the electronic client database before entering an exception request.
6. The DHSS Benefits Administrator will review documentation and contact the Case Manager or the ADAP and Core Services Director if further information is needed.

DOCUMENTATION:

1. Documentation related to the coverage gap
2. Health insurer or other payer source denials
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Miscellaneous Policies and Procedures have been established to provide client services which are broader in scope, or which fall outside of the normal parameters of ADAP and HICP assistance. Miscellaneous services are offered in accordance with State and Federal mandates.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for miscellaneous services. (HIV Case Management Manual Section 3.0).
2. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. Clients must abide by individual miscellaneous policies and submit all required documentation, in order to be considered for miscellaneous services.
4. Statewide Service referrals must be in "8ENR" status when services are rendered, if requesting payment assistance.
5. An Exception Request may be submitted for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. Examples of delays may include client's ability to obtain and submit required eligibility documentation, delays in processing Statewide Services referrals, etc. (Section 9.0)
6. There is no guarantee the Exception Request will be approved. (Section 9.0)

PROCEDURES:

1. Case Managers must consult individual miscellaneous policies and procedures for specific service requirements.
2. Case Managers must submit an Exception Request for emergency situations where a delay in Statewide Services enrollment could result in a barrier to care. Examples of delays may include the client's ability to obtain and submit required eligibility documentation, delays in processing Statewide Services referrals, etc. (Section 9.0)
3. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. See individual miscellaneous policies and procedures.

SUMMARY:

The DES Program is intended to provide an option for RW clients who do not require more intensive HIV Case Management, but who require financial assistance for Statewide Services or region specific supportive services. DES Program Services include:

1. HICP premium, deductible and co-pay assistance (Section 7.0)
2. Dental co-pay and deductible assistance (per individual RW Grantee policy)
3. Uninsured medication costs (Section 6.0)
4. Uninsured outpatient ambulatory costs (per individual RW Grantee policy)
5. Uninsured oral health/dental costs (per individual RW Grantee policy)
6. Uninsured mental health costs
7. MHN Spenddown

The following policies and procedures have been established to guide Case Managers through the required steps for establishing assistance for the DES Program in accordance with regional RW Grantee, State, and Federal mandates.

POLICY:

1. The DES Program is independent from HIV Case Management services.
2. The DES Program is available to clients whose incomes are 0-300% of the FPL.
3. DES clients are required to remain virally suppressed (>200 copies/ml).
4. DES clients are required to be self-sufficient to be eligible for initial enrollment in the DES Program.
5. DES clients are required to remain self-sufficient to be eligible for continued enrollment in the DES Program.
6. DES Program closure will be assessed by the DES Coordinator and DES supervisor if necessary.
7. Clients who are assessed as no longer being self-sufficient while participating in the DES Program may be considered for re-entry into the MO HIV Case Management Program.
8. Client's re-entry into the MO HIV Case Management Program (or re-entry into the DES Program) will be at the discretion the appropriate RW Grantee.

9. DES Program closure may include but is not limited to:
    a. Client is not virally suppressed according to the results of two consecutive labs, during a 12-month period.
    b. Client does not have a documented CD4/Viral Load lab result within a 12-month period.
    c. Client requires more intensive HIV Case Management services including assistance with supportive services such as substance use, etc.
    d. Client loss of DES Program eligibility due to over income limits, failure to return required DES Program updated eligibility documentation, etc.
10. Clients who want to be considered for re-enrollment into the DES Program must request re-enrollment with the DES Coordinator or their existing Case Manager and provide all required DES Program eligibility documentation; including documentation showing that all reasons for closure have been resolved, as applicable.
11. Clients will not be considered for DES Program re-enrollment until the specified amount of time for the closure has passed according to the client's closure or removal letter, if applicable.
12. Clients must be notified via postal mail if enrollment or re-enrollment into the DES Program is denied.

PROCEDURE:

1. The DES Coordinator and Case Managers use the most current forms located in the electronic client database.
2. The DES Coordinator and the client's existing Case Manager must assess the client for initial enrollment or re-enrollment into the DES Program.
3. The DES Coordinator must consult with the client's Case Manager, QSM and the DES supervisor regarding the client's enrollment or re-enrollment into the DES Program.
4. The DES Coordinator must document communication with the client's Case Manager, QSM or regional supervisor in the client's "Progress Note" in electronic client database.
5. The DES Coordinator must respond to the existing Case Manager via communicate with the final decision regarding enrollment or re-enrollment into the DES Program.

6. Case Managers must initiate a transfer from MO HIV Case Management to the DES Program using the current HIV Case Management transfer policy, if the client has been approved for DES Program enrollment or re-enrollment. (HIV Case Management Manual Subsection 7.3)
7. Case Managers must not complete a DES Program transfer for a client who requires a MO HIV Case Management Annual Update within 45-days of the transfer request.
8. Case Managers must ensure that all documentation and service referrals are current before requesting or attempting to initiate a client transfer. (HIV Case Management Data Rules)
9. The DES Coordinator must notify the client via the appropriate communication channels if the client is approved for DES Program enrollment.
10. The DES Coordinator must update appropriate modules in the electronic client database if the client is approved for DES Program enrollment. This includes making or updating appropriate service referrals for Statewide Services.
11. The DES Coordinator must notify the existing Case Manager, QSM and regional supervisor if the client is denied re-enrollment to the DES Program, so the client can remain in MO HIV Case Management, if eligible.
12. The DES Coordinator must notify the client via postal mail if enrollment or re-enrollment into the DES Program is denied.
13. The DES Coordinator must upload the client denial letter into the “Documents” module in the electronic client database.

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for establishing short-term assistance for ADAP formulary-covered ARVs for eligible clients who are incarcerated in a city or county jail or a justice-involved residential care setting. Services for clients who temporarily reside in a city or county jail or a justice-involved residential care setting are available in accordance with State and Federal mandates.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for RW Program short-term services while they are incarcerated in a city or county jail or reside in a justice-involved residential care facility, such as half-way houses, community-based supportive housing, etc. (HIV Case Management Manual Section 3.0)
2. RW Programs cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. RW Programs may provide core HIV medical and support services to people living with HIV incarcerated in a city or county jail or a justice-involved residential care setting on a short-term basis. This may include RW-eligible clients who are serving sentences imposed by a city or county jail or a justice-involved residential care setting if no other payer source exists.
4. HICP will not be available to clients while they are serving sentences imposed by a city or county jail.
5. Short-term Statewide Services will generally be approved for no more than 180 days at a time for clients who temporarily reside in a city or county jail or a justice-involved residential care facility.
6. RW Programs cannot pay for HIV core medical and support services provided to people living with HIV in Federal or State prison systems even on a short-term basis, because these services are generally provided by the Federal and State prison systems.
7. HIV Case Management can be provided via the Positive Start, Transitional HIV Case Management program.
8. The appropriate RW Grantee will be responsible for approving or denying the client's initial enrollment or continued enrollment in the MO HIV Case Management system and the short-

term ambulatory care referral(s).

9. The DHSS Benefits Administrator, or DHSS will coordinate with the appropriate RW Grantee regarding enrollment in HIV Case Management, short-term ambulatory care and short-term Statewide Services at the time of enrollment, during updates or as needed.
10. The city or county jail or the justice-involved residential care facility where the client temporarily resides must submit documentation stating the institution will not provide the requested service(s) before RW Programs consider approval to ensure there is no duplication of services.
11. Clients must submit a signed HSI Release of Information Form to allow the client's Case Manager and city or county jail or justice-involved residential care facility the ability to communicate about the client's HIV care. (Appendix A4)
12. Statewide Services will only provide short-term access to HIV treatment, which is in accordance with the HHS Clinical Guidelines for the Treatment of HIV based on individual client needs (i.e., HIV treatment regimens may vary depending on age, perinatal considerations, etc.).
13. Statewide Services will only provide access to ADAP formulary-included ARVs if the city or county jail or justice-involved residential care facility does not provide coverage through its formularies or when the client does not have access to other payer sources such as private insurance, MHN, Medicare, etc.
14. A new Exception Request for short-term Statewide Services and updated required documentation must be submitted before the end of the existing Exception Request approval, as needed. (Section 9.0)
15. Short-term Statewide Services will be stopped if the client is released into the DOC penal system, as applicable.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must submit an Exception Request to the appropriate RW Grantee and the DHSS Benefits Administrator to request that the client be allowed to access the HIV Case Management System, ambulatory care, and Statewide Services, as needed. (Section 9.0)

3. The appropriate RW Grantee will make a determination of eligibility for HIV Case Management and ambulatory care assistance, as needed.
4. The DHSS Benefits Administrator will review the required documentation and approve the Exception Request or contact the Case Manager, appropriate RW Grantee, or the ADAP and Core Services Director if follow-up is needed.
5. The appropriate RW Grantee and/or the ADAP Director will follow up with the Case Manager as needed.
6. Case Managers must upload all required documentation into the "Documents" module in the electronic client database before short-term Statewide Services can be provided.
7. Case Managers must document all communication between the city or county jail, justice-involved residential care facility, the client and the client's medical provider in the client's "Progress Note" or appropriate electronic client database module.
8. Case Managers must schedule the client's HIV related medical appointments that occur outside of the city or county jail, or justice involved residential care facility setting to ensure the client uses an in-network or contracted provider.
9. The city or county jail or justice involved residential care facility must provide a statement on their company letterhead indicating:
    a. The institution does not have resources to provide HIV care and/or treatment for the client.
    b. A list of services the institution will provide.
    c. The length of time expected for the client's stay in the institution.
    c. Guarantee that the client's Case Manager will have physical and phone access to the client to complete enrollment and follow-up.
    d. An agreement to transport the client to HIV-related medical appointments.
    e. Assurance that the client will have access to pharmacies (contracted with the DHSS Benefits Administrator, Pharmacy Benefits Manager (PBM) for all prescription refill(s) written by the client's medical provider, if applicable.
10. The institution may also be given the option to complete a Ryan White Short-Term Institutional Attestation Form in lieu of the written statement. (Appendix A3)

DOCUMENTATION:

1. MO HIV Case Management eligibility documents (HIV Case Management Manual Section 3.0)
2. HSI Release of Information Form (Appendix A4)
3. Institution's written statement
4. Ryan White Short-Term Institutional Attestation Form, if applicable (Appendix A3)
5. Exception request, if applicable
6. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Statewide Services may be able to provide short-term payment assistance for ADAP formulary covered ARVs for eligible clients who are admitted to some institutionalized settings when no other payer source exists. The following policies and procedures have been established to guide Case Managers through the required steps for establishing short-term assistance for clients who reside in various institutional settings (e.g., including skilled nursing facilities, etc.). Short-term services are available in accordance with State and Federal mandates.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for short-term Statewide Services. (HIV Case Management Manual Section 3.0).
2. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. Statewide Services will not generally assist MHN (only) clients with ARVS or other medications while they are inpatient in an institutionalized setting unless circumstances prevent the client from accessing ARVs through their MHN assistance.
4. RW clients who are dual-eligible (receiving both MHN and Medicare) may be eligible for short-term assistance with their ADAP formulary-covered ARVs for the first 100 days of being in an institutionalized setting. (After 100 days, ARVs and other medications should be covered under the client's Medicare Part D plan if the client is enrolled with Medicare Part D and if the medication is on the Part D plan's formulary.) Therefore, clients must pursue MHN or Medicare coverage prior to requesting Statewide Services assistance.
5. Clients who qualify must apply for a Medicare Part D plan that meets their HIV medication coverage needs and the LIS as soon as possible.
6. The appropriate RW Grantee will be responsible for approving or denying the client's initial enrollment or continued enrollment in the HIV Case Management system.
7. The DHSS Benefits Administrator or DHSS will coordinate with the appropriate RW Grantee regarding enrollment in HIV Case Management, ambulatory care assistance and Statewide Services at the time of enrollment, during updates, or as needed.
8. The institution where the client resides or will reside, must submit documentation stating the

institution will not provide the requested service(s) before Statewide Services will consider approval.

9. Clients must submit a signed HSI Release of Information Form to allow the client's Case Manager and the institution the ability to communicate about the client's HIV care. (Appendix A4)
10. Short-term Statewide Services will only provide access to ADAP formulary included ARVs if the institution does not provide coverage through its formularies or through other payer sources such as private insurance, MHN, Medicare, etc.
11. Short-term Statewide Services will generally be approved for no more than 180 days at a time.
12. A new Exception Request for short-term Statewide Services and updated required documentation must be submitted before the end of the existing Exception Request approval, as needed. (Section 9.0)

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must submit an Exception Request and contact the appropriate RW Grantee in order to request that the client be allowed to access the HIV Case Management System, ambulatory care assistance and Statewide Services, as needed. (Section 9.0)
3. The appropriate RW Grantee will make a determination of eligibility for HIV Case Management and ambulatory care assistance, as needed.
4. Case Managers must also submit an Exception Request for short-term coverage of ARVs for clients who have MHN (only) when there are circumstances, which prevent the client from accessing their MHN assistance for ARVs while in an institutionalized setting.
5. Case Managers must submit an Exception Request for short-term coverage of ARVs for clients who are dual-eligible and who require short-term Statewide Services assistance while in an institutionalized setting.
6. Case Managers must assist clients with enrolling in a Medicare Part D plan, which meets their HIV medication coverage needs as soon as the client is eligible, as well as the Medicare LIS, if applicable.

7. The DHSS Benefits Administrator will review the required documentation and approve the Exception Request or contact the HIV Case Manager, appropriate RW Grantee or the ADAP and Core Services Director if follow-up is needed. (Section 9.0)
8. The appropriate RW Grantee or the ADAP and Core Services Director will follow up with the Case Manager, as needed.
9. Case Managers must upload all required documentation into the "Documents" module in the electronic client database before short-term Statewide Services can be provided.
10. Case Managers must document all communication between the institution, the client and the client's medical provider in the client's "Progress Note" or appropriate electronic client database module. (HIV Case Management Manual Section 4.0)
11. Case Managers must schedule the client's HIV-related medical appointments that occur outside of the institutional setting to ensure the client uses an in-network or contracted provider.
12. The institution must provide a statement on their company letterhead indicating:
    a. The institution does not have the resources to provide HIV care and treatment for the client.
    b. The length of time expected for the client's stay in the institution.
    c. A guarantee that the client's Case Manager will have physical and phone access to the client to complete enrollment and follow-up.
    d. An agreement to transport the client to HIV-related medical appointments.
    e. Assurance that the client will have access to pharmacies (contracted with the Statewide Services PBM for all prescription refill(s) written by the client's medical provider, if applicable.
13. The institution may also be given the option to complete a Ryan White Short-Term Institutional Attestation Form in lieu of the written statement. (Appendix A3)

DOCUMENTATION:

1. MO HIV Case Management eligibility documents (HIV Case Management Manual Section 3.0)
2. HSI Release of Information Form (Appendix A4)

3. Institution's written statement
4. Ryan White Short-Term Institutional Attestation Form, if applicable (Appendix A3)
5. Exception Request, if applicable
6. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for obtaining access to preventative neonatal HIV treatment assistance for infants exposed to HIV.

POLICY:

1. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
2. Statewide Services may provide preventative neonatal treatment for infants exposed to HIV through either full payment or co-payment of HIV medication until an alternative payer source is available or until confirmatory HIV status for the infant has been confirmed by the infant's treating physician.
3. Infants with perinatal HIV exposure should be tested at the following intervals as recommended by the National Institutes of Health:
    a. 14 to 21 days
    b. One (1) to two (2) months
    c. Four (4) to six (6) months
4. Infants at high risk of perinatal HIV infection should be given additional virologic diagnostic testing recommended at birth and at two (2) to six (6) weeks after antiretroviral drugs are discontinued.
5. The appropriate RW Grantee will be responsible for approving or denying HIV Case Management and/or ambulatory care for the infant.
6. Statewide Services will only provide assistance if the treatment regimen follows the most currently approved HHS, HIV/AIDS neonatal guidelines. Statewide Services does not have a cap or income limitation for parents or guardians of presumptive positive infants.
7. Statewide Services do not require that the infant's parent(s) or caregiver(s) be enrolled in HIV Case Management prior to the infant being considered for assistance; however, the infant's mother must have verification of HIV status. (HIV Case Management Manual Section 3.0)
8. Consideration for neonatal preventative treatment assistance will be determined through the Exception Request process.

PROCEDURE:

1. Case Managers must use most current forms located in the electronic client database.
2. Case Managers must establish a new client record for the infant in the electronic client services database according to current MO HIV Case Management guidelines. (HIV Case Management Manual Section 3.0)
3. Case Managers must complete required enrollment modules in the electronic client services database. The modules must include the name and contact information for the infant's primary and/or specialty health care provider, if available. (HIV Case Management Data Rules)
4. Case Managers must upload the infant's mother's HIV positive status confirmation and other HIV Case Management-related enrollment documentation into the "Documents" module in the electronic client services database at the time of the infant's Statewide Services enrollment.
5. Case Managers must obtain proof of other payer sources and upload documentation to the "Documents" module in the electronic client services database, if available.
6. Case Managers must enter service referrals for the infant in the electronic client services database, as appropriate. (HIV Case Management Data Rules)
7. Case Managers must request medical information (CD4/Viral Load, Medical Information Release Form (MIRF), etc.) and update the infant's "Verified Medical Care" module upon request.
8. Case Managers must review and discuss prescribed medications with the infant's parents or caregiver throughout the infant's seroconversion period.
9. Case Managers must review and discuss the infant's engagement in preventative HIV medical care with the infant's parent(s) or caregiver(s):
    a. at the time of enrollment in HIV Case Management/Statewide Services;
    b. at three (3) months post-delivery at minimum; and
    c. more frequently, if needed.
10. Case Managers must discuss the infant's prescribed medication regimen, barriers to adherence, consequences of sub-optimal adherence, etc., with the infant's parent(s) or caregiver(s).
11. Case Managers must provide the infant's parent(s) or caregiver(s) an educational fact sheet

regarding HIV. The fact sheet must be reviewed with the parent(s) or caregiver(s) to ensure they are aware of risks associated with suboptimal HIV medication adherence, breastfeeding, etc.

12. Case Managers must assist with coordination and follow-up of the infant's HIV medical care, including coordination between the infant's parent(s), caregiver(s), and clinical care team (e.g., physician, pharmacist, etc.), as needed.
13. Case Managers must document all coordination activities, treatment outcomes, record requests, etc., in the infant's "Progress Note" in the electronic client services database.
14. Case Managers must upload the infant's virologic test results into the electronic client services database as soon as they are available.
15. Case Managers must contact the ADAP and Core Services Director and the appropriate RW Grantee via the electronic client services database communicate when the results have been uploaded.
16. The ADAP and Core Services Director will review the infant's virologic test result to determine continued eligibility for Statewide Services.
17. If the infant is determined not to be eligible for Statewide Services, the ADAP and Core Services Director will identify available funding sources to back-bill to reimburse RW Part B for costs incurred.
18. All additional funding sources and back-billing documentation will be added to the infant's record in the electronic client services database by the ADAP and Core Services Director.

DOCUMENTATION:

1. Verification of infant's mother's HIV+ status (HIV Case Management Manual Section 3.0)
2. Verification of infant's mother or caregiver's proof of residence (HIV Case Management Manual Section 3.0)
3. Verification of infant's health insurance (e.g., private insurance, Medicare, VA, MHN, etc.) if available (Section 7.0)
4. HSI Release of Information Form (Appendix A4)
5. Medical records for the mother and infant, such as CD4 and viral load counts, if available.
6. Infant's virologic test results
7. Educational fact sheet(s)

8. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The Successful Transition Exiting Prison (STEP) Program provides housing and support services to individuals who have been newly released from the MO DOC prison system or a Federal prison system and who become enrolled in the MO HIV Case Management system. STEP goals include:

a. improving the transition process between client incarceration and HIV-related medical care and services post-incarceration,
b. increasing client access to stable housing,
c. increasing access to other supportive services including utilities, transportation assistance, etc.,
d. continuing the client's enrollment and engagement in MO HIV Case Management, and
e. providing HIV/STD prevention education and risk reduction counseling.

The following policies and procedures have been established to guide Case Managers through the required steps for establishing STEP assistance for eligible clients in accordance with State and Federal mandates.

GENERAL STEP POLICY:

1. STEP Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for STEP services. (HIV Case Management Manual Section 3.0)
2. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. STEP services must be used within 12 months of a client's release to the community from State or Federal prison for a maximum of 12 months of assistance after their release date. (For example, if a client is released during April, they would have until April of the next year to use STEP services.)
4. STEP clients must complete six-month check-ins with their Case Manager. (HIV Case Management Manual Section 5.0)
5. If the MO HIV Case Management update occurs past the allowable 30-day update window, the client will lose that month of STEP assistance.

6. STEP clients must provide documentation of their release from State or Federal prison.
7. STEP clients must schedule an appointment for HIV medical care within the first 30 days of STEP assistance.
8. STEP clients must contact their Case Manager monthly for each month of requested assistance in order for the Case Manager to assess the client's continued need for STEP services.
9. STEP will provide assistance with the following:
    a. Rent deposits
    b. Monthly rental assistance
    c. Utility deposits
    d. Monthly utility assistance
    e. Transportation assistance
10. STEP will reimburse the client's RW contracted Case Management agency for required identification, including a copy of the client's birth certificate, State identification card or MO driver's license, if the agency can provide appropriate documentation of the purchase on a submitted invoice to the DHSS Benefits Administrator.
11. STEP clients must work with their Case Manager to complete a Budget Plan Worksheet Form upon enrollment into the STEP Program, or when the client's situation changes. (Appendix A7)
12. Case Managers may submit an Exception Request for financial or policy requirement considerations on behalf of STEP-enrolled clients if the client is encountering barriers to stability and cannot resolve them within existing STEP parameters.
13. Clients who are re-incarcerated while receiving STEP assistance must be disenrolled from the program while they are incarcerated. The client can be re-enrolled in STEP upon release if they otherwise qualify for the program. The client's re-enrollment will be counted as a new enrollment with renewed months of eligible assistance.

GENERAL STEP PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.

2. Case Managers must upload verification of the client's institutional release into the "Documents" module in the electronic client database using the document type, "Verification of Incarceration-1VERIF CAR".
3. Case Managers must complete all the "History of Incarceration" fields in the "Demographics" module in the electronic client database. (HIV Case Management Data Rules)
4. Case Managers must complete an area of assessment in the "Service Plan" module in the electronic client database, which describes:
    a. the client's plan to address short-term and long-term needs; and
    b. the client's progress toward self-sufficiency (e.g., how will the client be able to pay their rent and/or utilities for the remainder of the year? What is the client's plan to reduce expenses? etc.). (HIV Case Management Data Rules)
5. Case Managers must submit appropriate STEP service referrals in the electronic client database by selecting "HSI – STEP" regardless of service type (e.g., transportation, housing, or utilities).
6. Case Managers must make STEP service referrals for a maximum of six (6) months, as needed.
7. STEP referrals may coincide with the Case Management service referral dates but must not extend past the active "HIV Case Management" service referral end date. (e.g., if the MO HIV Case Management referral has one month left, the STEP referral must be entered for one month. The remaining five (5) months of STEP assistance must be accessed during the next "HIV Case Management" service referral dates, as needed.)
8. Case Managers must contact the DHSS Benefits Administrator to alert them that the six-month STEP client update has occurred.
9. The DHSS Benefits Administrator will update the STEP referral end date once the client has updated the Case Manager.
10. Case Managers must obtain all required documentation and upload into the "Documents" module in the electronic client database before entering STEP service referrals.
11. Case Managers must send the DHSS Benefits Administrator a communicate in the electronic client database detailing the type of assistance needed.

12. Case Managers must update the client's area of assessment in the "Service Plan" module of the electronic client database to include the required monthly contact for each month of requested assistance, to document the client's continued need for STEP services, if applicable.
13. Clients must work with their Case Manager to complete a Budget Plan Worksheet upon enrollment into the STEP Program, and if the client's situation changes. The completed Budget Plan Worksheet will be valid for all STEP assistance if completed within six (6) months of STEP enrollment. (Appendix A7)

DOCUMENTATION:

1. Client's institutional release
2. Budget Plan Worksheet (Appendix A7)
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

STEP HOUSING ASSISTANCE POLICY:

1. STEP clients are eligible for housing deposits and housing assistance for up to 12 months of services.
2. STEP clients who share a lease with another person or who have roommates must divide the deposit and/or rent by the number of unrelated adult members in the housing unit.
    a. A roommate relationship is defined as a person(s) named on the lease of the housing unit that he/she shares with the prime tenant or leaseholder and who shares responsibility for rent and utility bills in return for receiving a share of the available space. Consult with the HIV Support Services Coordinator for more information regarding single-room rental guidance.
3. STEP clients who wish to rent a single room within a shared housing unit may be eligible for up to the rate of assistance for a one-bedroom apartment in the client's area of the State.
4. Rent must be reasonable and cannot exceed the Fair Market Rent (FMR) for a one-bedroom apartment.

5. Clients, regardless of gender, who request additional bedrooms due to having full or partial custody of children must provide custody-related documentation (e.g., court orders, legal custody agreements, etc.).
6. STEP clients must work with their Case Manager to complete a Budget Plan Worksheet at the time of requested assistance, and when the client's situation changes. (Appendix A7)
7. STEP clients must obtain and submit a current lease agreement. If the lease agreement is a month-to-month agreement it must contain language that specifies the month-to-month status.
8. STEP clients must obtain and submit a current IRS Request for Taxpayer Identification Number and Certification Form (W-9) at the time assistance is requested and annually for established landlords. The client's landlord may also fax or mail a copy of the W-9 to the client's Case Manager.
9. STEP clients must obtain a current copy of the Housing Assistance Verification Form (HAV) from the landlord at the time assistance is requested or when the client's situation changes. The client's landlord may also fax or mail a copy of the HAV to the client's Case Manager. (Appendix A8)
10. STEP clients must work with their Case Managers to complete a Housing Related Rights and Responsibilities at the time of the request for assistance unless the form has been completed within the past year and must be updated with changes. (Appendix A9)

STEP HOUSING ASSISTANCE PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must update the client's "FINANCIAL – Housing/Living Situation" area of assessment in the "Service Plan" module of the electronic client database to include the required monthly contact for each month of requested assistance, to document the client's continued need for STEP services, if applicable.
3. The area of assessment must also document the client's need for continued STEP assistance. (HIV Case Management Manual Data Rules)

4. Case Managers must complete the "Housing" module in the electronic client database by selecting the appropriate "Housing Type" and the "Why Opened" dropdown option. Options include:

Housing Type	Why Opened
RW INST-Ryan White	Curr. Lvg. Arr. = Institution (prison)
RW N-PERM-Ryan White	Curr. Lvg. Arr. = Non-perm housed
RWN OTHR-Ryan White	Curr. Lvg. Arr. = Other
RW PERM-Ryan White	Curr. Lvg. Arr. = Permanently Housed

5. Case Managers must complete the "Demographics" fields as part of the "Social Supports" module in the electronic client database for everyone living in the housing unit.
6. Case Managers must upload all required documentation in the "Documents" module of the electronic client database before requesting STEP assistance.
7. Case Managers must contact the HIV Support Services Program Coordinator to request a Rent Reasonableness Certification prior to the client signing a rental agreement.
8. Case Managers must send a communicate in the electronic client database to the DHSS Benefits Administrator for each month of requested STEP services.

STEP HOUSING ASSISTANCE DOCUMENTATION:

1. Budget Plan Worksheet (Appendix A7)
2. Lease Agreement
3. IRS-Request for Taxpayer Identification Number and Certification (W-9)
4. Housing Assistance Verification Form (Appendix A8)
5. Housing Related Rights and Responsibilities Form (Appendix A9)
6. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

STEP MILEAGE REIMBURSEMENT POLICY:

1. STEP clients are eligible for mileage reimbursement for travel to community or advocacy agencies, or to public assistance agencies to apply for benefits such as food stamps,

disability, housing, VA services, etc. STEP mileage reimbursement may also be used to attend appointments with employment or career centers, meetings with Case Managers, Probation and Parole Officer visits, medical, mental health or substance use disorder treatment appointments and travel to pharmacies to pick up medication.

2. STEP clients who are actively enrolled in MHN must access MHN Non-Emergency Medical Transportation (NEMT) services before STEP medical transportation reimbursement will be approved.
3. STEP clients who have not met their monthly Spenddown requirement are not considered MHN active and may be eligible for STEP transportation reimbursement. (Subsection 7.4)
4. STEP clients must work with their Case Manager to complete a Transportation Request Form to be considered for STEP transportation reimbursement. All sections of the form must be completed to be considered for reimbursement. (Appendix A10)
5. STEP will only authorize one round-trip reimbursement, even if there are multiple appointments within the same day.
6. STEP will not authorize payment for more than one reimbursement request per calendar month.
7. STEP will not provide reimbursement for mileage, which exceeds the number of estimated "direct route" miles as reflected on mileage estimation websites such as Google Maps, etc.
8. STEP mileage reimbursement rates are $.65 cents per mile.
9. STEP will reimburse clients for a maximum of $400.00 per month.
10. STEP transportation reimbursement requests must be submitted to the DHSS Benefits Administrator by the 15th of the month after allowable appointments.

STEP MILEAGE REIMBURSEMENT PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must work with clients to complete a Transportation Request Form, if applicable. (Appendix A10)
3. Case Managers must upload all required documentation in the "Documents" module of the electronic client database before requesting STEP assistance.

4. Case Managers must update the "FINANCIAL—Transportation" area of assessment in the "Service Plan" module of the electronic client database to include the required monthly contact for each month of requested assistance and document the client's continued need for STEP services, if applicable.
5. The "FINANCIAL – Transportation" area of assessment must also document the client's need for continued STEP assistance.
6. Case Managers must send a communicate in the electronic client database to the DHSS Benefits Administrator for each month of requested services.

STEP MILEAGE REIMBURSEMENT DOCUMENTATION:

1. Budget Plan Worksheet (Appendix A7)
2. Transportation Request Form (Appendix A10)
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

STEP BUS PASS POLICY:

1. STEP clients are eligible to receive bus passes to travel to medical, social support, and essential service appointments, if available in the client's region.
2. STEP will only provide bus pass assistance if the client does not have access to private transportation.
3. Public transportation agencies that provide bus services must have a current contract with the DHSS Benefits Administrator.
4. Case Management agencies may purchase monthly bus passes for distribution to clients if the transportation agency does not have a contract with the DHSS Benefits Administrator.
5. RW Program contracted Case Management agencies may seek reimbursement for bus pass purchases if appropriate documentation of the purchase is submitted by invoice to the DHSS Benefits Administrator.

STEP BUS PASS PROCEDURE:

1. Case Managers must update the "FINANCIAL—Transportation" area of assessment in the "Service Plan" module of the electronic client database to include the required monthly

contact for each month of requested assistance and document the client's continued need for STEP services, if applicable.

2. The "FINANCIAL – Transportation" area of assessment must document the client's need for continued STEP assistance.
3. Case Managers must upload all required documentation in the "Documents" module of the electronic client database before requesting STEP assistance.
4. Case Managers must send a communicate in the electronic client database to the DHSS Benefits Administrator for each month of requested services.
5. Case Managers must use the most current forms located in the electronic client database.

STEP BUS PASS DOCUMENTATION:

1. Budget Plan Worksheet (Appendix A7)
2. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

STEP UTILITY ASSISTANCE POLICY:

1. STEP clients are eligible for a one-time utility deposit assistance.
2. STEP clients are eligible to receive monthly utility assistance for a maximum of twelve months.
3. STEP clients are eligible for the full amount of a utility deposit and the full amount of monthly utilities, unless there are multiple adults residing in the household.
4. STEP clients who have roommates must divide the utility deposit and/or utility bill(s) by the number of adult members in the housing unit.
5. STEP clients must work with their Case Manager to complete a Budget Plan Worksheet. (Appendix A7)
6. STEP clients must submit requests for utility deposits and monthly utility bills to their Case Manager. The utility deposit or bill(s) must be in the client's name and reflect the amount of the utility deposit or monthly bill.

STEP UTILITY ASSISTANCE PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.

2. Case Managers must work with clients to complete a Budget Plan Worksheet. (Appendix A7)
3. Case Managers must update the "FINANCIAL—Housing/Living Situation" area of assessment in the "Service Plan" module of the electronic client database to include the required monthly contact for each month of requested assistance and document the client's continued need for STEP services, if applicable.
4. The "FINANCIAL – Housing/Living Situation" area of assessment must also document the client's need for continued STEP assistance.
5. Case Managers must upload all required documentation in the "Documents" module of the electronic client database before requesting STEP assistance.
6. Case Managers must send a communicate in the electronic client database to the DHSS Benefits Administrator for each month of requested services.

STEP UTILITY ASSISTANCE DOCUMENTATION:

1. Budget Plan Worksheet (Appendix A7)
2. Utility deposit statement or monthly utility bill
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for establishing assistance for medical supplies (adult incontinence briefs only) when they cannot be provided through other payer sources.

POLICY:

1. Clients must meet the minimum HIV Case Management eligibility criteria in order to qualify for the Statewide Service Medical Supply Program. (HIV Case Management Manual Section 3.0)
2. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. Medical supplies are authorized or provided based on specific criteria and funding availability.
4. Adult incontinence briefs are the only authorized supply allowed under the Medical Supply Program.
5. Uninsured ADAP clients are eligible to obtain incontinence briefs through the Medical Supply Program.
6. Clients who have active health insurance coverage including private insurance, Medicare, MHN, etc. must contact their health insurance provider to see if adult incontinence briefs are a covered supply before requesting them through the Medical Supply Program.
7. Clients who are enrolled in the MHN, SPPC or AIDS Waiver Program must access incontinence briefs directly through MHN, if the supplies are covered.
8. Clients must provide a physician's order from their medical care provider that reflects a demonstrated need for incontinence briefs to be considered for the Medical Supply Program. The physician's order must be on the physician's official letterhead.
9. Medical supplies must be requested by an Exception Request through the DHSS Benefits Administrator. (Section 9.0)
10. Exception Requests must be attached to the "HSI – Ambulatory/Outpatient Medical Care" or "HSI – Ambulatory/Outpatient Medical Care Co-pays" service referral.
11. Exception Requests will be authorized for a maximum of six (6) months. The Exception Request must not exceed the length of the current "HSI – Ambulatory/Outpatient Medical

Care" or "HSI – Ambulatory/Outpatient Medical Care Co-pays" service referral. The service referral must be in an "8ENR" status.

12. The medical supplies provider must contact the DHSS Benefits Administrator for pre-authorization each month (or as needed) for payment of incontinence briefs.

PROCEDURE FOR PRIVATELY INSURED CLIENTS:

1. Case Managers must submit an Exception Request for medical supplies according to Statewide Services Data Rules by attaching it to the client's "HSI – Ambulatory/Outpatient Medical Care" or "HSI – Ambulatory/Outpatient Medical Care Co-pays" service referral. The Exception Request must indicate that the request is for medical supplies only. (Section 9.0)
2. The DHSS Benefits Administrator will open a new "HSI – Ambulatory/Outpatient Medical Care" (full-pay) service referral for clients who do not have a referral in "8ENR" and use the appropriate "Encounter."
3. The service referral cannot exceed six-months. (e.g., some RW clients who are eligible for MHN, Medicare, etc. are not normally enrolled in RW outpatient ambulatory services and will not have an active service referral.)
4. Case Managers must obtain a physician's order from the client or the client's medical provider that reflects a demonstrated need for incontinence briefs.
5. Case Managers must upload all required documentation into the "Documents" module in the electronic client database before submitting an exception request for medical supplies.
6. Case Managers may contact the ADAP and Core Services Director or the DHSS Benefits Administrator via telephone or electronic client database communicate to alert them that an exception request for medical supplies has been requested, if it is an emergency situation.
7. The ADAP and Core Services Director or the DHSS Benefits Administrator will review the required documents and approve or deny the Exception Request.
8. The DHSS Benefits Administrator will contact the Case Manager if issues arise with the medical supplies provider.
9. The DHSS Benefits Administrator will contact the ADAP and Core Services Director for follow-up or guidance, as needed.

10. Case Managers must submit a new service referral for medical supplies along with all required documentation if supplies are needed beyond the initial six-month request or prior to the "his – Ambulatory/Outpatient Medical Care" service referral end date.

PROCEDURE FOR MHN MEDICAL SUPPLY EXCEPTION REQUESTS:

1. Case Managers whose clients are enrolled in MHN program(s) must coordinate with the client's physician to complete a MHN Exception Request Form with as much detail as possible to prevent delays in the MHN approval process, as needed. (The completed MHN Exception Request form will satisfy the physician order requirement.)
2. Case Managers must assist clients in submitting the MHN Exception Request, if needed.
3. Case Managers must follow-up with clients to see if they have received an approval from MHN for the exception request. (MHN should review the exception request within 15 working days.
4. If approved, the client; the client's physician; and the service provider for the medical supply should be notified. In the case of a denial, only the prescriber and the participant will receive a notification letter.)
5. Case Managers must follow general Medical Supply Program processes to complete the medical supply exception request, if needed.

DOCUMENTATION:

1. Exception Request Narrative clipping
2. Physician order on letterhead
3. MHN Exception Request Form
4. Insurer or MHN denial letter, if applicable
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for requesting extensions of service during a natural disaster or emergency.

POLICY:

1. Clients must meet the minimum HIV Case Management eligibility criteria in order to be eligible for RW Program emergency services. (HIV Case Management Manual Section 3.0)
2. RW Programs cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. Clients who are late in completing a HIV Case Management update, or who require an extension of services (e.g., ambulatory care, emergency housing services, extra medication refills, etc.) due to a natural disaster or emergency may be granted one 30-day extension, without the need for an Exception Request.
4. If another prescription fill extension is requested due to delays in required program updates, etc. approvals will be limited to a standard 30-day fill.
5. Clients may be granted extra extensions for services if the natural disaster or emergency extends beyond 30-days.
6. An Exception Request may be required for consideration of extensions of services beyond the initial 30-days. (Section 9.0)
7. The appropriate RW Grantee will be responsible for approving or denying HIV Case Management and ambulatory care or other region specific service extensions.
8. The ADAP and Core Services Director will be responsible for approving or denying an Exception Request for medication. (Medication refills will only include those, which are currently on the ADAP formulary.)

PROCEDURE:

1. Case Managers use the most current forms located in the electronic client database.
2. Case Managers must attach the Exception Request to the appropriate service referral in the electronic client database.
3. Case Managers must add a detailed “Progress Note” in the electronic client database documenting why an extension of services is needed.

4. Case Managers must include a detailed description explaining all barriers associated with not having access to the services as part of the Exception Request.
5. Case Managers must modify the appropriate service referral in the electronic client database to include the initial 30-day extension. (HIV Case Management Data Rules)
6. Case Managers must attach a "Progress Note" to the appropriate service referral(s) explaining the reason for the extension request. (The language can be copied from the progress note, or the Case Manager can state, "Client requests a 30-day extension for an emergency/crisis, see Progress Note.")
7. Case Managers must contact the DHSS Benefits Administrator to inform them that the client is experiencing a natural disaster or emergency. (This can be done via electronic client database communicate or by telephone.)
8. Case Managers must send the ADAP and Core Services Director an electronic client database communicate and copy the DHSS Director of Case Management, the appropriate RW Grantee, the appropriate DHSS regional QSM and others per their Case Management agency protocol before the end of the initial 30-day extension, if further extensions are being requested.
9. The appropriate RW Grantee will investigate the client's emergency situation and contact the DHSS Benefits Administrator if needed.
10. The appropriate RW Grantee will contact the Case Manager as soon as possible if an exception request needs to be made to extend services.
11. Case Managers must upload all supporting documentation into the "Documents" module in the electronic client database, before submitting an exception request.

DOCUMENTATION:

1. Exception Request Narrative clipping, if applicable
2. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The Centers for Disease Control (CDC), reports that people with HIV are more likely to develop harmful consequences from tobacco usage than those without HIV. The following policies and procedures have been established to guide Case Managers through the steps for evaluating client interest in tobacco cessation for improving health outcomes.

POLICY:

1. Clients who have an ADAP, HICP, or Spenddown service referral must have a completed Missouri Tobacco Use Assessment. (Appendix C1)
2. All other clients must have a new Missouri Tobacco Use Assessment or complete the tobacco use question as part of the Missouri Case Management Assessment Tool (MCMAT) upon enrollment into Statewide Service Programs and at minimum during the client's annual update. (HIV Case Management Manual Subsection 4.2)
3. Clients who wish to receive smoking cessation treatment assistance should utilize other payer sources for tobacco cessation treatment products, if available. (Other payer sources may include health insurance, MHN, etc.)
4. HICP clients who wish to receive smoking cessation treatment assistance may access tobacco products on the most current ADAP formulary if no other payer source is available.

PROCEDURE:

1. Case Managers must complete a Missouri Tobacco Use Assessment or have clients complete the tobacco use question as part of the MCMAT upon client enrollment into Statewide Services. (HIV Case Management Manual Subsection 4.2)
2. Case Managers must complete a new Missouri Tobacco Use Assessment or complete the tobacco use question as part of the MCMAT at minimum during the client's Annual Update.
3. Case Managers must evaluate the client's willingness to address tobacco use upon enrollment into Statewide Services and at the time of the client's Annual Update.
4. Case Managers must follow the HIV Case Management Individual Service Plan (ISP) policy for completing a tobacco cessation action plan for clients who are interested in tobacco cessation. (HIV Case Management Manual Section 4.0)

5. Case Managers must provide resources to clients who are interested in tobacco cessation. Resources may include educational materials, a copy of the most current ADAP formulary, or helping clients access Tobacco Use Prevention and Control, smokefree.gov, American Lung Association, etc.
6. Case Managers must encourage clients to ask their physicians about tobacco cessation and assist clients in obtaining tobacco cessation treatment from non-ADAP resources, if available. (Other payer sources may include health insurance, MHN, etc.)
7. Case Managers must document in the client's "Progress Note" in the electronic client database when other payer sources cannot be utilized for tobacco cessation products.
8. Case Managers must document in the client's "Encounter" module in the electronic client database when a client declines participation in tobacco cessation activities.

SUMMARY:

Secondary claims are paid by the DHSS Benefits Administrator according to specific protocol in order to ensure programmatic and fiscal compliance with Statewide Service Programs. The following policies and procedures have been established to ensure compliance with timely filing of claims for clients who have active health insurance coverage.

POLICY:

1. Payment cannot be made for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
2. Clients must utilize all other available sources of payment to ensure RW remains the payer of last resort.
3. Healthcare providers must accept third-party payment in order for the DHSS Benefits Administrator to pay medical care claims.
4. Some services may not be covered by Statewide Services. Please see the most current ADAP and HICP Service Limitation and Exclusion List in the electronic client database. (MO Support Files\ADAP)
5. Co-payment referrals must be in "8ENR" status when costs are incurred if requesting co-payment assistance.
6. Clients must generally work within their health insurance network and limitations.
7. Clients will not be eligible for assistance once they reach their health insurance plan coverage caps or limitations (i.e. additional co-payments or other services).
8. Clients must submit a health insurance provider Explanation of Benefits (EOB) along with the provider claim(s) if they wish to receive Statewide Services co-payment assistance.
9. Provider claim(s) for service dates six-months or less from the date of submission to the DHSS Benefits Administrator are eligible for assistance if the service is otherwise eligible according to policy.
10. Provider claim(s) for service dates over six-months but less than 12 months from the date of submission to the DHSS Benefits Administrator are outside of the approved time frame. However, the claim may still be paid without the need for an Exception Request, if the delay

in submitting the claim is due to systems issues (i.e., insurer delayed claims or EOBs, etc.) and if the service is otherwise eligible according to policy.

11. Provider claim(s) for service dates over 12 months from the date of submission to the DHSS Benefits Administrator are outside of the approved time frame but may be considered for payment; however, they must be accompanied by:
    a. An Exception Request (Section 9.0);
    b. Provider claim;
    c. EOB;
    d. Proof of the provider's timely filing with the primary insurance plan; and
    e. Explanation from the provider for why the claim is past the six-month to one-year timeline for filing the claim.
12. Provider claim-related Exception Requests must be submitted per client and not batched per provider to ensure appropriate documentation in the client record.
13. There is no guarantee that provider claims which are dated over one year from the date of service will be paid.

PROCEDURE:

1. Case Managers must verify whether services are eligible for co-payment assistance by consulting the most current ADAP and HICP Service Limitation and Exclusion List located in the electronic client database, prior to requesting co-payment assistance on behalf of clients. (MO Support Files\ADAP)
2. Case Managers must submit provider claims per client and cannot be batched per provider, to ensure appropriate documentation in the client record.
3. Case Managers must complete an Exception Request and attach it to the appropriate service referral in the electronic client database for any claims submitted to the DHSS Benefits Administrator more than 12 months from date of service.
4. Case Managers must upload all required documentation into the client's "Documents" module in the electronic client database, prior to requesting co-payment assistance for secondary payment of health insurance claims.

DOCUMENTATION:

1. Provider claim
2. EOB
3. Exception request, if applicable
4. Proof of the provider's timely filing, if applicable
5. Provider explanation of why the claim is past the six-month to one-year timeline for filing, if applicable
6. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Statewide Services may assist privately insured clients with co-payments for residential, social setting detox, and outpatient substance use treatment services. Substance use treatment claims will be paid by the DHSS Benefits Administrator according to specific protocol in order to ensure programmatic and fiscal compliance with Statewide Service Programs.

POLICY:

1. Payment cannot be made for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
2. Clients must utilize all other available sources of payment to ensure RW remains the payer of last resort.
3. Substance use treatment providers must accept third-party payment in order for the DHSS Benefits Administrator to pay substance use treatment claims.
4. Some substance use treatment services may not be covered by Statewide Services. Please see the most current ADAP and HICP Service Limitation and Exclusion List in the electronic client database. (MO Support Files\ADAP.)
5. All "HSI – Substance Abuse Treatment Services Co-pays" referrals must be in "8ENR" status when costs are incurred if requesting substance use treatment co-payment assistance.
6. Clients must generally work within their health insurance network and limitations.
7. Residential, social setting detox, and outpatient substance use treatment service claims will be limited to 30-days per calendar year for allowable services.
8. Clients will not be eligible for assistance once they reach their health insurance plan coverage caps or limitations (i.e. additional co-payments or other services).
9. Clients must submit a health insurance provider EOB along with the provider claim(s), if they wish to receive Statewide Services co-payment assistance.

PROCEDURE:

1. Case Managers must verify whether services are eligible for co-payment assistance by consulting the most current ADAP and HICP Service Limitation and Exclusion List located

in the electronic client database, prior to requesting co-payment assistance on behalf of clients. (MO Support Files\ADAP)

2. Case Managers must verify whether services are eligible for co-payment assistance by consulting the client's health insurance plan Summary of Benefits and Coverage.
3. Case Managers must upload all required documentation into the client's "Document" module in the electronic client database, prior to requesting co-payment assistance for secondary payment of inpatient substance use treatment claims.

DOCUMENTATION:

1. Provider claim
2. EOB
3. Summary of Benefits and Coverage
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Exception Requests may be granted for services, which exceed or are broader in scope than existing service limits or are outside of current established programmatic guidelines. The following policies and procedures have been established to guide Case Managers through the necessary steps for submitting Exception Requests for Statewide Services.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for an Exception Request. (HIV Case Management Manual Section 3.0)
2. Statewide Services Exception Request processes are not intended to be applied in any situation in which the client is in physical jeopardy or requires an immediate determination; therefore, Statewide Services processes cannot be used to address emergencies.
3. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source. Other payer sources may include:
    a. Private health insurance plans
    b. Other public assistance programs (Medicare, MHN)
    c. HIV Patient Assistance Programs (PAPS)
    d. Pharmaceutical company discount programs (various)
    e. Prescription discount programs i.e. (various)
4. There is no guarantee that an Exception Request will be approved.
5. The appropriate RW Grantee will be responsible for approving or denying Exception Requests for HIV Case Management and Ambulatory Care.
6. Exception Requests for Statewide Services, which have been denied by the DHSS Benefits Administrator will be forwarded to the ADAP and Core Services Director for follow-up, as needed.
7. Exception Requests for clients that do not meet Statewide Services eligibility criteria or Exceptions for medications not currently on the ADAP formulary must be forwarded directly to the ADAP and Core Services Director.

8. Clients must submit all documentation, which would support the need for an Exception Request before notifying the DHSS Benefits Administrator or the ADAP and Core Services Director.

PROCEDURE:

1. Case Managers must use the most current forms located in the electronic client database.
2. Case Managers must insert an Exception Request for clients that do not meet Statewide Services eligibility criteria or medications, and attach it to the appropriate service referral, according to the Statewide Services Data Rules. (Appendix C1)
3. Case Managers must select the appropriate service referral for which the exception is being requested and resubmit the service referral in "1EXC -- Exception Submitted" status.
4. Case Managers must include a detailed description as part of the Exception Request Narrative clipping explaining all barriers the client may face that are associated with the request.
5. Case Managers must upload all supporting documentation in the "Documents" module in the electronic client services database prior to submitting the Exception Request.
6. The ADAP and Core Services Director or the DHSS Benefits Administrator will review the required documents and approve or deny the Exception Request.
7. The ADAP and Core Services Director or the DHSS Benefits Administrator will contact the Case Manager if follow-up is needed.

DOCUMENTATION:

1. Exception Request Narrative clipping
2. Supporting documentation
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The APTC is a federal subsidy available to individuals and families who earn 100%-400% of the FPL. The ACA Marketplace may have assigned an APTC to some HICP clients who are or were enrolled in an HICP approved health insurance plan, depending on the amount of income reported to Healthcare.gov. The following policies and procedures have been established to guide Case Managers through the necessary steps for requesting payment of APTC penalties on behalf of clients.

POLICY:

1. Statewide Services cannot assist with non-APTC penalties.
2. Statewide Services will not generally assist with APTC penalties due to clients not reporting income accurately to Healthcare.gov or the IRS.
3. Clients must coordinate payment to the IRS, or have the penalty deducted from their tax refunds.
4. Statewide Services will only consider payment of an APTC Exception Request if the penalty has been assessed by the IRS due to circumstances beyond the client's control. (e.g., systems issues, incorrect data entry, etc.)
5. There is no guarantee the Exception Request will be approved.
6. Statewide Services cannot pay penalties assigned to a non-client or spouse, if filing jointly. (See IRS form Attachment 8962 or Federal Tax Form 1040).
7. Statewide Services will not reimburse clients when the APTC tax liability is deducted directly from the client's income tax refund. The APTC penalty must be a remaining APTC penalty balance owed to the IRS.
8. The IRS must be willing to accept third-party payment for the APTC outstanding penalty.
9. Statewide Services cannot make direct payment to clients if the IRS will not accept payment or rejects payment of the APTC penalty.
10. Statewide Services will authorize payment of APTC penalties based on the most current HRSA policies and funding availability.

PROCEDURE:

1. Case Managers must submit an Exception Request if the client requests that the APTC penalty be paid prior to June 30 to be considered for APTC liabilities for the previous year.
2. Case Managers must clearly document the circumstances related to the APTC penalty as part of the Exception Request.
3. The ADAP and Core Services Director will review the APTC penalty payment Exception Request and approve or deny payment, as appropriate.
4. The ADAP and Core Services Director will contact the Case Manager if follow-up is needed.
5. Case Managers must upload a typed or clearly written statement into the "Documents" module of the electronic client database, which includes:
    a. Client's proper name (no aliases)
    b. Client's Social Security Number
    c. Client's street address and
    d. Client's APTC liability or total dollar amount due (as shown on IRS form Attachment 8962 and on line 29 of the Federal Tax Form 1040).
6. The DHSS Benefits Administrator will submit the written statement with payment to the IRS, to help ensure the payment is applied correctly to the client's IRS account.
7. Case Managers may request an IRS payment status update by contacting the DHSS Benefits Administrator via the electronic client database, if needed.

DOCUMENTATION:

1. Exception Request Narrative clipping
2. IRS Form Attachment 8962
3. Federal IRS Tax Form 1040, if applicable
4. Written statement to the IRS
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for requesting a limited supply of ADAP formulary covered medication when clients temporarily travel out of MO.

30-DAYS OR LESS POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria and be actively enrolled in ADAP or HICP in order to qualify for assistance with extra refills of medication when temporarily traveling out of MO. (HIV Case Management Manual Section 3.0)
2. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. Clients who are actively enrolled in ADAP or HICP, may receive an extra 30-day supply of ADAP formulary covered medications no more than one-time per calendar year.
4. Insured clients or their pharmacy must contact their health insurance provider to verify that the health insurance provider will allow an extra refill prior to requesting ADAP assistance.
5. Clients must provide proof of denial if the extra 30-day medication refill has been denied by the health insurance provider. A pharmacist may attest to the medication denial if no other proof is available.
6. An Exception Request will be required if the client requests the extra 30-day fill after leaving the State.
7. There is no guarantee an Exception Request(s) will be approved.

LONGER-TERM REQUEST POLICY:

1. Clients who are traveling out of MO for longer than 30-days, must request prior approval to remain in HIV Case Management in order to obtain additional months of medication refills.
2. The appropriate RW Grantee will be responsible for approving or denying HIV Case Management Services for clients who are traveling out of MO and who will be gone longer than 30-days.
3. Clients who have health insurance must confirm with the insurance provider that a 90-day fill

can be accommodated.

4. Clients who consistently travel out of MO for work purposes and who have documented proof of out of state employment do not need an Exception Request submitted in order to fill their medication for up to 90-days.
5. Clients who consistently travel out of MO for work purposes may request an exception for more than 90-days of medication fills.
6. Clients who are traveling out of MO for non-emergency or non-work related reasons will not generally be approved for full-pay re-fills over 30-days.
7. Insured clients who are traveling out of MO for non-emergency or non-work-related reasons may not be approved for co-pay assistance on re-fills over 30-days, if the insurer denies the extra fill request.
8. Clients who have traveled out of MO for longer than 30-days must have a face-to-face meeting with their Case Manager when they return to MO, in order to reinstate ADAP or HICP services.
9. There is no guarantee an Exception Request(s) will be approved.

PROCEDURE:

1. Case Managers must complete an Exception Request for extra refills of medication on behalf of all clients who have left MO prior to requesting an extra medication refill. (Section 9.0)
2. Case Managers must document in the client's "Progress Note" in the electronic client database if a pharmacist has attested to a health insurer's medication refill denial.
3. Case Managers must submit an Exception Request and notify the appropriate RW Grantee when a client is traveling out of State for more than 30-days if the client wishes to remain in HIV Case Management; and if extra refills of medication are requested by the client. (Section 9.0)
4. Case Managers must submit an Exception Request and notify the appropriate RW Grantee when a client is traveling out of State for more than 90-days if the client wishes to remain in HIV Case Management; and if extra refills of medication are requested by the client. (Section 9.0)
5. Case Managers must upload all supporting documentation into the "Documents" module in

the electronic client database, before submitting an Exception Request.

6. Case Managers must include a detailed description explaining all barriers associated with not having access to the extra refills of medication as part of the Exception Request.
7. Case Managers must attach the "Exception Request Narrative" clipping to the appropriate Statewide Service referral in the electronic client database. (Appendix C2)
8. The appropriate RW Grantee will review for continued HIV Case Management enrollment.
9. The ADAP and Core Services Director or the DHSS Benefits Administrator will review medication specific Exception Requests and submitted documentation in order to make a final approval or denial decision.
10. The appropriate RW Grantee and the ADAP and Core Services Director will contact the Case Manager if follow-up is required.
11. The DHSS Benefits Administrator will change the client's service referrals to a "6CSM" status until the client returns to MO.
12. The Case Manager must notify the DHSS Benefits Administrator via electronic client database communicate once they have verified that the client has returned to MO, if the client requires Statewide Services to resume, regardless of the length of time the client has been traveling outside of MO.
13. When reinstating a client, the DHSS Benefits Administrator will change the client's service referral(s) to the appropriate status after the Case Manager has verified the client's return to MO.

DOCUMENTATION:

1. Exception Request Narrative clipping, if applicable
2. Health insurer or provider denial, if applicable
3. Current employment documentation, if applicable
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Statewide Services have established the following policies and procedures to guide Case Managers through the required steps for requesting a limited supply of ADAP formulary covered replacement medication when a client loses their medication or have had their medication stolen.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for assistance with lost or stolen medication. (HIV Case Management Manual Section 3.0)
2. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. A one-time 30-day supply of ADAP formulary covered medications may be approved for eligible clients who have had their medication lost or stolen. A one-time supply is defined as one-time annually.
4. Clients who have active health insurance coverage must contact their health insurance provider and be denied an extra medication refill due to it being lost or stolen, prior to requesting ADAP assistance.
5. Clients who have had mail-order medications stolen must arrange with their pharmacy to sign for future deliveries of the medication to prevent future theft from occurring.

PROCEDURE:

1. Case Managers must submit an Exception Request for a one-time 30-day supply of ADAP formulary covered medications for an eligible client who has had their medication lost or stolen, if requested by the client. (Appendix C1)
2. Case Managers must include a complete description of the circumstances, which resulted in lost or stolen medication.
3. Case Managers must upload all supporting documentation into the “Documents” module in electronic client services database, before submitting an Exception Request.
4. Clients whose medication was stolen are encouraged to file an official police report regarding stolen medication.

5. The ADAP and Core Services Director or the DHSS Benefits Administrator will review the required documents and approve or deny the Exception Request.
6. The ADAP and Core Services Director or DHSS Benefits Administrator will contact the Case Manager if follow-up is needed.

DOCUMENTATION:

1. Exception Request Narrative clipping
2. Health insurer or other payer source denial, if applicable
3. Official police report, if applicable
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to guide Case Managers through the required steps for requesting ADAP assistance for non-ADAP formulary covered medication.

POLICY:

1. Statewide Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
2. Statewide Services will not cover non-ARV medications, which are not included on the current ADAP formulary.
3. Statewide Services will consider Exception Requests for ARVs not currently covered on the ADAP formulary if all other potential payment sources have denied coverage of the ARV. (Section 9.0)
4. Clients who have active health insurance coverage must review their health insurance provider formulary, prior authorization, or Exception Request process for ARV coverage, before requesting ARV assistance through Statewide Services.
5. The client's prescribing physician must provide a statement on company letterhead indicating the negative health consequences for the client if the client were to be denied access to the non-ADAP covered ARV.
6. There is no guarantee that the Exception Request will be approved.

PROCEDURE:

1. Case Managers must submit an Exception Request if requesting a non-formulary covered HIV medication. (Appendix C1)
2. Case Managers must upload all supporting documentation in the "Documents" module in the electronic client database before submitting the Exception Request.
3. Case Managers must include a detailed description explaining all issues or challenges associated with the client not being able to access the non-covered ARV and the estimated length of time for Statewide Service coverage as part of the Exception Request.
4. Case Managers may contact the ADAP and Core Services Director and copy the DHSS Benefits Administrator via telephone, or electronic client database communicate to alert them that an exception request clipping has been attached to the appropriate service referral if a

client's situation is urgent.

DOCUMENTATION:

1. Other payer sources denial
2. Physicians statement
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

Appendix A1

Missouri Medicaid Screening Tool

Missouri Medicaid Screening Tool

Client Name:	Client DCN:

Instructions: Eligibility for MO HealthNet depends on a client's income, age, health, and individual needs. This form must be completed at each Enrollment and Annual Update if

the client is not already applied or enrolled in Medicaid. Questions are to be answered in order until an answer designates the process is complete.

The questions below have been designed to determine **Medicaid Eligibility.**

1. Is the client a resident of MO?
   - ☐ No – **PROCESS COMPLETED. Client does not need to apply for Medicaid.**
   - ☐ Yes, continue.

2. Is the client a United States Citizen or Legal Resident?
   - ☐ No – **PROCESS COMPLETED. Client does not need to apply for Medicaid.**
   - ☐ Yes, continue.

3. Disability Determination: Have you been found to be disabled or do you consider yourself to be disabled?
   - ☐ No, continue
   - ☐ Yes – **PROCESS COMPLETED. Client needs to apply for Medicaid.**

4. Are you 65 or older or a minor child (under 19 years old)?
   - ☐ No, continue
   - ☐ Yes – **PROCESS COMPLETED. Client needs to apply for Medicaid.**

5. Do you have minor children in your household?
   - ☐ No, continue
   - ☐ Yes – **PROCESS COMPLETED. Client needs to apply for Medicaid.**

6. Does the client make less than the annual income limit of (<138%) for their current family size?
   - ☐ No – **PROCESS COMPLETED. Client does not need to apply for Medicaid.**
   - ☐ Yes - **PROCESS COMPLETED. Client needs to apply for Medicaid**

Client eligible for Medicaid? ☐ **YES** ☐ **NO**

Case Manager:_____ **Date:**_____

Revised October 2023

Appendix A2

AIDS Drug Assistance Program (ADAP)/Health Insurance Continuation Program (HICP) Affidavit of Missed or Declined Health Insurance Form

AIDS Drug Assistance Program (ADAP)/
Health Insurance Continuation Program (HICP)
Affidavit of Missed or Declined Health Insurance Form

Client Name: _____ **DCN:** _____

Please read the following information carefully and review with your case manager before completing this form. (Please check the statement(s) that apply to your situation.)

☐ I have *missed* the opportunity to enroll in one or more of the following comprehensive health insurance options for the following reason(s). I understand that I will be expected to pursue comprehensive health insurance coverage at the next available opportunity as part of the current Missouri (MO) ADAP/HICP requirements. (Please check all that apply.)

☐ ACA (Affordable Care Act/Marketplace) ☐ Employer-Based Insurance ☐ Medicare

☐ Other:_____

Reason(s) for missed health insurance enrollment: _____

☐ I am choosing to *decline* the following comprehensive health insurance policy(s): (Please check all that apply.):

☐ ACA (Affordable Care Act/Marketplace) ☐ Employer-Based Insurance ☐ Medicare

☐ Other:_____

Reason(s) for declining health insurance enrollment: _____

Next Open Enrollment Period: _____

Please also initial beside each statement to indicate you have read and understand what each statement means.	
	I understand that ADAP does not provide minimum essential coverage defined by the ACA and is not considered an insurance plan.
	I understand that some health coverage provider(s) could refuse to provide me with health care services due to a lack of health insurance coverage.
	I understand that ADAP will not generally assist with medications that are not reflected on the most current MO ADAP formulary.
	I understand that ADAP/HICP eligible individuals are expected to be enrolled in health insurance that offers basic or minimum essential coverages such as outpatient services, emergency services, hospitalization, prescription drugs, laboratory services, preventative and wellness services, chronic disease management, etc.
	I understand that if it is my choice not to enroll in or utilize other available health coverage, it may increase the likelihood that I could be placed on an ADAP/HICP waiting list, or that I could lose my ADAP/HICP assistance if funding decreases or goes away.
	I have read information about the benefits of having health insurance and the information has been explained to me in a way that I understand it.

I agree that I will not hold ADAP/HICP responsible for correcting or compensating me for services or consequences that occur as a result of not having or using other available health insurance coverage.

_____ _____ _____
(Client's Printed Name) (Client's Signature) (Date)

Appendix A3

Ryan White Short-Term Services Institutional Attestation Form

Ryan White Short-Term Services Institutional Attestation Form

The Ryan White System has the ability to provide services to clients who are institutionalized in a variety of settings including skilled nursing facility, city/county jail, residential treatment settings, etc. When a person is institutionalized, payer of last resort must be documented. Documentation from institution must be obtained stating facility will not provide requested service(s) before services are provided.

Facility Name: _____

Facility Address: _____

Name: _____ Date of Birth: _____

Estimated length of stay _____

Next hearing date (jail only) _____

Discharge/Release Date _____

Please have an Administrator initial the boxes below and sign at the bottom of this form. This information is to attest that the institution will agree to the following terms as a means to coordinate HIV care for the client.

☐	The case manager will have physical and/or phone access to the client to complete any documentation and gather needed information.
☐	The institution will transport the client to all medical appointments related to HIV.
☐	Medical appointments related to HIV must be scheduled with an approved Ryan White medical Provider.
☐	The institution will ensure access to fill all prescription(s) written by the medical provider.
☐	If medications are funded by Ryan White, the medication must be filled by an ADAP approved pharmacy.

Transportation will not be reimbursed by the Ryan White system. If needed, the institution can coordinate the scheduling of medical appointments with the Ryan White Medical Case Manager.

Official signature on this line attests that the institution will not provide payment for the HIV related service(s) or HIV medications requested for client.

Signature Title Date

Appendix A4

HSI Release of Information

HSI (Healthcare Strategic Initiatives)

AUTHORIZATION TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ DCN: _____

Birth Date: _____ SS#: _____

Address: _____

City: _____ State/Zip: _____

Phone: (Home) _____ Phone: (Work/Cell) _____

I, _____ the undersigned, authorize and request **HSI** to release information to the following individual(s):

Partner ☐ Parent ☐

Name: _____

Address: _____

Phone: _____

The following information may be disclosed (**initial all that apply):**

_____ Proof of HIV

_____ Required eligibility documentation

_____ Health related information

_____ Health insurance information

For the purpose of all HSI/Direct Enrollment Services,

Which may concern substance abuse, psychiatric treatment, insurance information, or HIV/AIDS testing and treatment. This authorization is effective for no longer than **1 year** from the date on which it is signed. I understand that this authorization can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance upon consent. I hereby release any person, agency, facility, or organization from any liability or legal responsibility from information furnished pursuant to this authorization.

Signed: _____ Date: _____

HSI/DES Worker: _____ Date: _____

Revised May 2024

Appendix A5

HSI Employer Verification Form

Employer Insurance Verification Form		
Date:		
Section 1		
Employee Name:		
Employee Address:		
Employee Social Security #:		
Company Name, Address, & Telephone:		
HR Contact Information:		
Employee is eligible for employer insurance coverage: ☐ Yes ☐ No		
If **No**, please explain:		
Next available open enrollment date (if applicable):		
Company accepts 3rd party payments: ☐ Yes ☐ No ☐ Monthly ☐ Quarterly **If NO, stop here and complete section 3. If YES, please complete section 2.**		
Section 2		
The employee has been provided an insurance benefit summary: ☐ Yes ☐ No		
Monthly Premium Amount:		
Medical: $	Dental: $	Vision: $
Make checks payable to:		
Mail premium checks to:		
HSI will be sending each payment, via the US postal service certified mail, by the third week of the month before the payment is due. This is to ensure the payment is posted timely and the coverage is active on the first date of the next month. If you have any further questions in regards to this arrangement or any changes in premiums, please contact Carol Laure at claure@nextgen.com or Kathy Weible kweible@nextgen.com at 877-541-6822.		
Section 3		
HR Representative Signature:		
Return completed form to:	Fax Number:	

Appendix A6

Care Services Health Insurance Premium Assistance Program Release Form

Care Services Health Insurance Premium Assistance Program Release Form
Healthcare Strategic Initiatives, L.L.C.

This Section only to Insurance/Employer/COBRA Carrier:

Client's Name: _____ **DCN #:** _____ **DOB:** _____

I authorize my insurance company to communicate with HSI insurance program specialist about my premiums and benefit coverage while I am engaged in Case Management services and actively receiving health insurance premium and/or co-pay and deductible assistance through this federal program.

Clients Signature: _____ **Date:** _____

- ☐ By signing this form, I hereby enroll in the Care Services Health Insurance Premium Assistance Program administered by Healthcare Strategic Initiatives, L.L.C. ("HSI").
- ☐ I hereby authorize HSI to coordinate payment of insurance premiums for the insurance policy with Case Manager(s), insurance carrier(s), and/or employee benefit department(s) listed on this form.
- ☐ I also hereby authorize HSI to discuss my medical condition and insurance premium information with my Case Manager(s).
- ☐ I understand that HSI will keep all information it obtains regarding my medical diagnosis(s) and other medical or cost information confidential. I also understand that without my prior written consent, HSI will not release the above information to any person other than the Case Manager(s) listed below.
- ☐ I understand that HSI is merely acting in an administrative role to assist with processing my health insurance premiums through the Care Services Health Insurance Premium Assistance Program, and that HSI does not in any manner accept responsibility or liability for maintaining my insurance coverage or paying for any medical care, and accordingly, I hereby release HSI from an liability should insurance policy lapse, be canceled, or terminated, regardless for the reason of such lapse, cancellation, or termination.
- ☐ I understand that my premium assistance may cease if it is determined that this program's formulary drugs are not covered on my health insurance.
- ☐ I understand that it is my responsibility to notify my Case Manager or HSI of any changes in my premium within five (5) working days.
- ☐ I understand that insurance premium payments are time sensitive and must be paid within the required time frame set forth by the insurance company's information packet. I understand all premiums that are due prior to my enrollment to this program are my responsibility unless I am found to be otherwise eligible for assistance.
- ☐ I understand that continuation in the Insurance Program is based on the availability of federal funds.

Client's Signature: _____ **Date:** _____

Witness: (i.e. CM* or CAC)** _____ **Date:** _____

**Case Manager **Certified Application Counselor*

*This form must be signed by a competent adult. If the person whose confidential information to be released is under the age of 18, or incompetent, then this release must be signed by a parent, guardian, or other qualified personal representative.

Until this form is returned and scanned into the client-level data application, HSI will be unable to continue premium assistance.

Appendix A7

Budget Plan Worksheet

Budget Plan Worksheet

Client Name:			
Date:		**DCN:**	

	Resources	Month	Month	Month	Comments
1	Gross Client/Family Income				
2	Rent/Utility Assistance (include LIHEAP, local community resources, **HOPWA**, Section 8, etc.)				
3	Food Stamps				
4	Other regular support from an absent family member or someone not living in the housing unit				
5	Other assistance (use comments to explain)				
6	**Total Resources**				

List actual expenses being paid each month in the appropriate categories.

	Expenses	Month	Month	Month	Comments
7	Rent				
8	Mortgage				
9	Utilities (heat, electric, water, sewer)				
10	Food				
11	Cell Phone				
12	Home Telephone				
13	Trash Service				
14	Child Care				
15	Gasoline				
16	Transportation				
17	Automobile Payment				
18	Automobile Insurance				
19	Medical Co-Pays/Expenses				
20	Health Insurance				
21	Cable/Satellite TV				
22	Internet				
23	Loans/Debt (what type)				
24	Payroll Deductions				
25	Payroll Deductions				
26	Other (Use comments to explain in more than one word)				
27	Other (Use comments to explain in more than one word)				
28	Other (Use comments to explain in more than one word)				
29	**Total Expenses** (line 7 thru 28)				
30	**Total Income/Resources** (line 6)				
31	**Balance** (line 30 – line 29)				

Client Name:	Enter the client's legal first and last name.
Date:	Enter the date that the form is being completed.
DCN:	Enter the client's eight-digit DCN number.
Resources Insert each amount into the first available column labeled "Month."	
1. Gross Client/Family Income	Enter the total monthly amount of gross income that the client and all gross income for their spouse and dependents, if applicable.
2. Rent/Utility Assistance (include LIHEAP, local community resources, HOPWA, Section 8, etc.)	Enter the total amount of assistance that the client receives per month for rent and utilities. Only include the amount of assistance that a client **currently** receives and note the program name in this column (e.g. HOPWA, Section 8, etc.). If the client is **not currently** receiving assistance from a program, insert $0.
3. Food Stamps	Enter the total amount of food stamps that the client receives per month.
4. Other regular support from an absent family member or someone not living in the housing unit	Enter the total amount of other financial support the client receives per month from other family members/individuals who do not reside in the home.
5. Other assistance (use comments to explain)	Enter the total amount of any other financial assistance the client may receive per month that does not fall into the above-itemized resources.
6. Total Resources	This field automatically adds 1 to 5 in the fillable PDF. **Note:** If you are not using the fillable PDF, you must total rows 1 to 5.
Expenses Insert each mount into the first available column labeled "Month"	
7. Rent	Enter the total amount of rent per month that the client is responsible for. Insert a comment if the client has a roommate(s) to document the cost difference between the Housing/Utility Calculation Worksheet and the lease.
8. Mortgage	Enter the total amount of the client's mortgage per month.
9. Utilities (heat, electric, water, sewer)	Enter the total estimated amount for utilities per month that the client is responsible for. Insert a comment if the client has a roommate(s) to document that the client is only responsible for a portion of utility costs.
10. Food	Enter the estimated amount of food costs for the client, their spouse, and their dependent(s) per month. This amount may be different than the amount of food stamps the client receives, if any.
11. Cell Phone	Enter the total monthly cost for the client's cell phone bill.
12. Home Telephone	Enter the total monthly cost for the client's home telephone bill.
13. Trash Service	Enter the total monthly cost for trash services. If the trash service is billed quarterly, divide the quarterly amount by three to get a monthly amount.
14. Child Care	Enter the client's total monthly cost of unreimbursed child care expenses. Do not include expenses that are reimbursed or are paid by another payer source.

15. Gasoline	Enter the client's total monthly cost for gasoline.
16. Transportation	Enter the client's total unreimbursed transportation costs, such as expenses for bus passes, taxis, etc. Do not include reimbursed transportation costs or expenses paid for by another payer source.
17. Automobile Payment	Enter the total monthly automobile payment for the client's personal automobile.
18. Automobile Insurance	Enter the total monthly insurance for the client's automobile.
19. Medical Co-Pays/Expenses	Enter the total amount of unreimbursed monthly medical co-pays or other medical expenses. Do not include expenses that are reimbursed to the client or paid for by another payer source.
20. Health Insurance	Enter the total health insurance premium cost per month for the client. Do not include premiums paid for by other payer sources.
21. Cable/Satellite TV	Enter the client's total monthly cable and/or satellite cost.
22. Internet	Enter the client's total monthly internet cost.
23. Loans/Debt (what type)	Enter the total monthly amount the client pays towards a loan or debt not listed above. If an amount is inserted in this column, a note must be put in the "Comments" column to explain what the loan or debt is.
24. Payroll Deductions **25. Payroll Deductions**	Enter any monthly payroll deductions such as restitution payments or child support but excluding employer insurances and taxes from wages. If the client has more than one payroll deduction, insert each amount on a separate line. A note must be put in the "Comments" column to explain what the payroll deduction is for.
26. Other (Use comments to explain in more than one word) **27. Other (Use comments to explain in more than one word)** **28. Other (Use comments to explain in more than one word)**	Enter the total of any other unreimbursed monthly expense the client has that is not itemized above. A note must be put in the "Comments" column to explain what the expense is. Each expense amount should be listed on a separate line with a separate note in the "Comments" column.
29. Total Expenses (line 7 thru 28)	This field automatically adds rows 7 – 28 in the fillable PDF. **Note:** If you are not using the fillable PDF, you must add the total of rows 7-28 and insert the total in this field.
30. Total Income/Resources (line 6)	This field automatically adds rows 1-5 in the fillable PDF. **Note:** If you are not using the fillable PDF, you must insert the amount from row 6 (the total of rows 1-5) in this field.
31. Balance (line 30 – line 29)	This field automatically subtracts the total of row 29 from the total of row 30 if you are using the fillable PDF. **Note:** If you are not using the fillable PDF, you must subtract row 30 from row 29 in this field. If the amount is negative, a minus sign must be inserted in front of the amount.

Appendix A8

Housing Assistance Verification Form and Instructions

Healthcare Strategic Initiatives

HOUSING ASSISTANCE VERIFICATION (HAV) FORM

This form must be completed upon request for assistance unless the HAV has been completed within the past year or with any changes.

TENANT INFORMATION

Tenant Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

****
****

REMAINDER OF INFORMATION TO BE COMPLETED BY LANDLORD ONLY

Lease Term: _____ to _____
(Please include Start Date, even if Lease is Month to Month)

When the lease expires does it:
- ☐ go month to month?
- ☐ automatically renew?
- ☐ annual signing?

Number of Bedrooms: _____ Number of tenants in residence: _____

Amount of Deposit: _____ Amount of Rent: _____

Does rent include payment for the following? ☐ Gas ☐ Electric ☐ Water ☐ Sewer ☐ Trash
(Check all that apply)

LANDLORD INFORMATION

Please check the appropriate box below:

☐ The lessee is a member of my family related by birth, marriage, or adoption.

☐ The lessee is **not** a member of my family related by birth, marriage, or adoption.

Owner Name: _____ Phone Number: _____

Owner Address: _____
Street Address

_____
City State Zip

Check Payable to: _____ Phone Number: _____
(If different from owner) Fax Number: _____
Email: _____

Mail Rent Check to: _____
(If different from owner address) Street Address

_____
City State Zip

Healthcare Strategic Initiatives

HOUSING ASSISTANCE VERIFICATION (HAV) FORM

This form must be completed upon request for assistance unless the HAV has been completed within the past year or with any changes.

I hereby agree to rent the aforementioned property to this tenant for the amount stated above. I understand that any housing/utility assistance provided is transitional in nature and not to provide long term assistance. I also agree to accept payment from the third-party payer on a month-to-month basis to either pay in full or assist with this monthly rental payment. There is no contractual obligation on either the part of the third-party payer (HSI) or landlord and I understand that this does not in any way obligate landlord or HSI any lease/tenant agreement. I understand that HSI is legally required to obtain a completed and signed Form W-9 from the owner of the property every year that payment is made by HSI. I understand that no rental checks will be released without a completed W-9.

I also understand this assistance is based on calculation of the client's income and Fair Market Rent (FMR) for this county. Any change in said income or FMR rate may affect the portion for which the client(s) is responsible. If there is a change in the eligible amount of assistance, you will receive a Housing Assistance Notification letter stating the amount of rent to be paid by the rent as well as HSI. This assistance program is dependent on the client's full participation and agreement to follow all policies, and if not followed, the program assistance could end without notice.

Property Owner/Rent Recipient Signature: _____

Date: _____

The HAV is used to verify tenant and landlord information. This form must be completed upon request for assistance unless the HAV has been completed within the past year or with any changes.

1. Case manager or Tenant should complete the "Tenant" section of the form including:
    a. Tenant Name- Name should be listed as the resident's (client's) legal name and must be consistent with the name entered in the Client Profile in the electronic client-level database.
    b. Tenant Address-Address on the Housing Assistance Verification form must match the address listed on the lease **and** in the Housing module in the electronic client-level database.
2. The HAV should be completed upon the agreement of the signed lease/tenant contract. The information presented in this section must be able to be verified in the lease.
3. Landlord should complete the "Landlord Only" section of the form including:
    a. Lease Term Start and End Date
    b. Lease Renewal Option
    c. Deposit and Rent Amount
    d. Utilities included or not included in Rent Amount
    e. The number of bedrooms should include what is verifiable as being a bedroom.
    f. The number of tenants in the residence must be verifiable by the listed number of "Tenants" listed within the lease. The number of tenants in the residence should be consistent with the number of household members being claimed in the Social Supports module of the electronic client database.
4. The Landlord is responsible for completing the following sections of the form; information must be clear and legible for processing of financial assistance.
    a. Family Member – One box must be check marked identifying if the Tenant and Landlord is family or not.
    b. Owner Name and Phone Number – If the Owner/Landlord name and the Check Payable to information is the same, only completing the owner section of this form is acceptable. Phone number should be current and valid.
    c. Owner Address – The complete address is important for mailing purposes, i.e., Apartment Letter and/or Number or if adding an "Attn:" line item.

d. Check Payable to – If the Owner/ Landlord name and the Check Payable to information is different.

e. Fax Number and/or Email – The program provides Automated Clearing House Direct Deposit for "Tenants/Clients" that are eligible for Long Term HOPWA Housing Assistance. The fax and/or email will be used solely as the first point of contact between Owner/Landlord and the DHSS Benefits Administrator for confirmation of program eligibility and introducing ACH Direct Deposit for assistance directly to the Owner/Landlord banking account.

5. Owner/Landlord Signature and Date – Signature and date are required from Property Owner and/or Rent Recipient i.e., Property Manager, Leasing Agent, Regional Manager, etc. for this document to be acceptable

6. **If the Landlord Address changes, please notify DHSS Benefits Administrator by changing the HSI - Housing Srvs/HOPWA/Rental Subsidy or HSI - Housing Srvs/RW/Rental Subsidy service referral to 2SRR and inserting a note regarding the Landlord Address change in information.**

Appendix A9

Housing Related Rights and Responsibilities

Housing Related Client Rights and Responsibilities

The following statements outline your rights and responsibilities for accessing housing services through the Ryan White Part B program.

I have a responsibility for the following:

- Provide a copy of the lease, prior to signing or moving into the property.
- Follow the terms of the lease agreement once all parties have signed the lease.
- Participate in the development of a plan of care to address my long-term housing stability.
- Allow the program to complete a housing inspection and rent reasonableness review prior to moving into the property to verify eligibility for assistance.
- Notify my Case Manager and Healthcare Strategic Initiatives (HSI) 30 days **prior** to moving to a new property.
- Maintain regular contact with my Case Manager and notify them of any changes in my income, household size, and/or living arrangements when they occur.
- Apply for and maintain active applications for local housing assistance programs.
- Provide true and accurate information pertaining to my eligibility for housing assistance.
- Provide all documentation to verify my eligibility in a timely manner.
- Pay the portion of housing costs over the amount of assistance I receive, including any amount of Fair Market Rent (FMR) and Rent Reasonableness standards.
- Pay my portion of rent, if any, as it is outlined in my lease agreement.
- Notify my Case Manager immediately if I am unable to pay my utilities.
- Take care of the property and leave it in the same condition as it was in prior to moving in.
- To **not** participate in any illegal activity in or outside of my residence. If I participate in illegal activity in or outside of my residence, I understand that I will no longer be eligible for housing assistance.

I have a right to the following:

- Receive timely, respectful services without regard to age, race, gender, disability, religion, sexual orientation, or whether I am a survivor of domestic violence, dating violence, sexual assault, or stalking.
- Receive copies of all signed documents pertaining to my housing services.
- Participate in the development of a plan of care to address my long-term housing stability.
- Receive an explanation of income calculations and factors used to determine the amount of assistance I am eligible to receive.
- Have my confidentiality maintained regarding my health conditions, but understand that my Case Manager and/or HSI may need to communicate with my landlord regarding documentation and financial assistance. Information regarding service eligibility will be shared on an "as needed" basis.
- Be informed of the terms and expectations of my housing assistance services and consequences if I do not comply with them.
- Appeal decisions through the Case Management grievance process.

I have read and understand the above statements regarding my rights and responsibilities for housing assistance. I understand that housing assistance is not permanent and availability may be limited if federal funding changes. I further acknowledge that failure to comply may result in suspension or termination of housing assistance.

Client Signature: _____ Date: _____

Appendix A10

Transportation Request Form and Instructions

Transportation Request Form

Type of Request (check all that apply): ☐ Consumer ☐ Medical	Travel Month:	County:
Does the client have Medicaid? ☐ Yes ☐ No	If yes, why was Medicaid Transportation not utilized?	
Client Name:	DCN:	**Total Gas Card Value:**
Agency:		Consumer Group Total:
Case Manager:		Medical Transportation Total:
Case Manager's Phone Number:		Gas Card Type: ☐ QT ☐ Prepaid Visa Fuel Card

Prepaid Card Reminders
Initial prepaid card requests may take 4 weeks to receive. It is important to **keep** your prepaid card to allow for quicker reimbursement at your next request. You must have a valid mailing address and phone number on file to receive a prepaid card.

☐ Send new prepaid card
☐ Reload current prepaid card
Last 4 digits: _____

Travel Date	Type of Travel	Name of Provider	Complete Address & Phone Number	No. of Miles	Rate $0.65/mile	Total
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
	☐ Consumer ☐ Medical				$0.65	
					Total:	

Clients receiving Medicaid benefits are required to use Medicaid Transportation to access Medicaid funded services.

I understand that my Case Manager and/or HSI will verify appointments listed on this form for accuracy. Fraudulent information may result in the termination of transportation services. Transportation services are intended to reimburse a client for medical transportation expenses for the treatment of his/her primary medical diagnosis. Request must be completed in full and should be forwarded to HSI by your Case Manager **no later than the 15th of the month following the dates of travel.** Please list only trips occurring during the same calendar month on a single request form. Incomplete requests will be returned to your Case Manager and will result in delayed reimbursement.

Client Signature:	Date:
Case Manager Signature:	Date:

Your signature above indicates that you have verified the above information to be true and accurate.

Type of Travel (Check One):	Check the box next to the appropriate type(s) of travel for the client's mileage reimbursement request.
Travel Month:	Select the travel month from the drop-down menu. **Note:** If you are not using the fillable PDF, you must insert the appropriate month for the travel reimbursement request.
County:	Select the appropriate county from the drop-down menu that the client resides in. **Note:** If you are not using the fillable PDF, you must insert the county that the client resides in.
Does the client have Medicaid?	Check the box next to the appropriate answer for the client.
If yes, why was Medicaid Transportation not utilized?	Enter the reason the client did not utilize Medicaid transportation, if applicable.
Client Name:	Enter the client's legal first and last name.
Total Gas Card Value:	This field automatically inserts the total of mileage reimbursement amounts inserted below. **Note:** If you are not using the fillable PDF, you must insert the total of all rows with mileage reimbursement amounts from the table below.
Agency:	Enter the name of the case management agency.
Consumer Group Total:	This field automatically inserts the total mileage reimbursement for Consumer Group travel. **Note:** If you are not using the fillable PDF, you must calculate the total of all rows marked "Consumer" in the "Type of Travel" column from the table below.
Case Manager:	Enter the first and last name of the client's case manager.
Medical Transportation Total	This field automatically inserts the total of mileage reimbursement for Medical travel. **Note:** If you are not using the fillable PDF, you must calculate the total of all rows marked "Medical" in the "Type of Travel" column from the table below.
Case Manager's Phone Number	Enter the case manager's 10 digit phone number.
Gas Card Type:	Check the box next to the name of the gas station that the client wants to receive their reimbursement gas card to.
Travel Date (all rows)	Enter the date of travel in the first available row. Each separate date must be inserted on a separate row. (Only one date per row).
Type of Travel (all rows)	Check the appropriate box for the date of travel. Only check one box. **Note:** If using the fillable PDF, calculations may not reset if you check both boxes in the same row.
Name of Provider (all rows)	Enter the name of the provider(s) that the client traveled to for the date of travel.
Complete Address & Phone Number (all rows)	Enter the complete address and phone number for the provider that the client traveled to for the date of travel.
No. of Miles (all rows)	Enter the round-trip number of miles that the client traveled on the date of travel. Only one round-trip will be reimbursed per day. Round-trip includes travel from home to the provider and return to the client's home.

Rate $0.65/mile (all rows)	The amount entered in this column is the amount per mile that the client will be reimbursed.
Total (all rows)	This field automatically multiples the number of round-trip miles by $0.65. **Note:** If you are not using the fillable PDF, you must multiply the total in the "No of Miles" field by $0.65.
Total:	This field automatically adds all of the totals of mileage reimbursement from the entries above. **Note:** If you are not using the fillable PDF, you must add the amount of reimbursement totals from above and insert the amount in this field.
Client Signature:	The client must sign on this line.
Date:	Enter the date that the client signed the completed form.
Case Manager Signature:	The Case Manager must sign on this line.
Date:	Enter the date that the Case Manager signed the completed form.

Appendix B1

Statewide Services Terminology

SUMMARY:

Standard terminology is used to describe and explain medical care and insurance terms across health systems. The following definitions and explanations of important concepts and insurance terms are frequently used as part of Statewide Services eligibility determinations and the payment of healthcare related claims.

1. **Advanced Personal Tax Credit:** A tax credit individuals take in advance to lower monthly health insurance payment (or "premium"). When applying for coverage in the ACA Marketplace, individuals must estimate expected income for the year. If the person qualifies for a premium tax credit based on their estimate, they can use any amount of the credit in advance to lower health insurance premiums.
    a. If at the end of the year someone has taken more premium tax credit in advance than they are due based on their final income, they will have to pay back the excess to the IRS when they file their federal income tax return.
    b. If they have taken less than they qualify for, they will get the difference back as part of their IRS refund.
2. **Affordable Care Act:** The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, or "Obamacare"). The law has three primary goals:
    a. Make affordable health insurance available to more people. The law provides consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the FPL.
    b. Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.) Missouri has not expanded Medicaid as of April 2019.
    c. Support innovative medical care delivery methods generally designed to lower the costs of health care.
3. **Ambulatory (Outpatient) Care:** Ambulatory (Outpatient) care includes the provision of professional diagnostic and therapeutic services issued directly to a client by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or another health care professional certified in his or her jurisdiction to prescribe medication therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where

clients generally do not stay overnight. (Emergency room services are not considered outpatient settings.)

4. **Ambulatory (Outpatient) Services:** Ambulatory (Outpatient) services may include:
    a. Diagnostic testing
    b. Early intervention and risk assessment
    c. Preventive care and screenings
    d. Practitioner examination, medical history taking
    e. Diagnosis and treatment of common physical and mental conditions
    f. Prescribing and managing medication therapy
    g. Education and counseling on health issues
    h. Continuing care and management of chronic conditions
    i. Referrals to and provision of specialty care (includes all medical subspecialties)
5. **Antiretrovirals:** Antiretroviral drugs are referred to as ARVs. Combination ARV therapy (ART) is referred to as ART. Highly effective ART is referred to as HAART.
6. **Comprehensive Health Insurance:** Comprehensive health insurance is an insurance policy that wholly covers health-related charges incurred from a stay in a hospital or a doctor's visit, post-deductible, and coinsurance payments.
7. **Copayment:** An amount paid as an individual's share of the cost for a medical service or item, like a doctor's visit or prescriptions.
8. **Coinsurance:** An individual's share of the cost for a covered health care service, usually calculated as a percentage (like 20%) of the allowed amount for the service.
9. **Deductible:** The amount owed for covered health care services before health insurance begins to pay.
10. **Explanation of Benefits:** An Explanation of Benefits provides details about a medical insurance claim that has been processed. The EOB explains what portion has been paid to the health care provider and what portion of the payment, if any, is the patient's responsibility. The EOB is not a bill. Any portion of the medical expense not covered by the insurance company, such as a deductible or a co-payment, will be billed by the provider and should be paid directly to the provider.
11. **Formulary:** A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

12. **Incarceration:** "Incarceration refers to the involuntary confinement of an individual in connection with an alleged crime. It includes involuntary confinement, either where a sentence has been determined or where the individual is detained pending adjudication of the case, as well as community supervision, such as parole or home detention." (Per HRSA PCN 18-02.) Statewide Services considers incarceration to only include individuals who are admitted to State and federal prison systems as part of the Department of Corrections.
13. **Inpatient Facilities:** Inpatient facilities include hospitals, nursing homes, rehab facilities, etc. (RW Programs generally cannot be provide services to clients who are being cared for in inpatient facilities.)
14. **Limitations and Exclusions:** Limitations and exclusions are lists of medical services and equipment a health plan won't pay for. This ranges from a type of drug to a type of surgery.
15. **Low Income Subsidy/Extra Help:** The Medicare LIS (also called Extra Help) Program helps people with limited income and resources pay for their Medicare premiums and prescription drug costs. QMB and SLMB are part of the LIS/Extra Help Program.
16. **Network:** A health insurer's network includes the doctors, hospitals, and suppliers that have been contracted with to deliver health care services to their members.
17. **Premium:** The monthly amount paid for an individual's health insurance plan.
18. **Primary Medical Care:** Primary medical care covers a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with patients and advise and treat them on a range of health related issues. They may also coordinate patient care with various specialists.
19. **Primary Payer (Payment):** A primary payer is the first or main source of payment for a good or service. Ryan White is required to be payer of last resort and may not always be the primary payer. (SWS Manual Sections 5.0, 6.0 and 7.0)
20. **Qualified Medicare Beneficiary Program**: The QMB Program is a Medicaid program that pays an individual's Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.
21. **Roommate:** A roommate relationship is defined as a person(s) who is **not named on the lease** of the housing unit that he/she shares with the prime tenant or lease holder; and who

shares responsibility for rent and utility bills in return for receiving a share of the available space.

22. **Secondary Payer (Payment):** A secondary payer is a person or entity that pays second on a claim for medical care. The payment is only to the extent that payment has not already been made. A secondary payer may be either a Medicare, Medicaid, or other insurance depending on the situation.
23. **Securing Client Outcomes Using Technology (SCOUT):** Electronic database used by the MO RW HIV Case Management system.
24. **Short-Term Basis:** Short-term basis refers to the HRSA specified time-limited provision of core medical and support services that are not prohibited by the statutory payer of last resort requirements.
25. **Specified Low Income Medicare Beneficiary Program:** The Specified Low Income Medicare Beneficiary **(**SLMB**)** Program is a Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.
26. **Summary of Benefits and Coverage:** An easy-to-read summary that can be used to make comparisons of costs and coverage between health plans. The SBC is made available by health insurance companies.
27. **Third-Party Payer:** A Third-Party Payer is a person or entity who pays, or agrees to pay for items or services such as health insurance premiums, co-payments, etc. on behalf of an individual on the basis of contractual agreements or eligibility for Federal, State, or local governmental benefits.
28. **Transitional Basis:** Transitional basis refers to the HRSA specified time-limited provision of appropriate core HIV medical and support services for the purpose of ensuring linkage to and continuity of care for incarcerated PLWH who will be eligible for RW Program services upon release, when such release is imminent; generally 180 days or fewer.

Appendix B2

Statewide Services Acronyms

Acronym	Formal Term
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
APTC	Advanced Personal Tax Credit
ART	Antiretroviral Therapy (ART)
ARV	Antiretroviral Drugs
CHIP	Children's Health Insurance Program
CM	Case Manager
COBRA	Consolidated Omnibus Budget Reconciliation Act
DCN	Document Control Number
DES	Direct Enrollment Services
DHSS	Department of Health and Senior Services
DOC	(MO) Department of Corrections
DoD	Department of Defense
FDA	U.S. Food and Drug Administration
FMR	Fair Market Rent
FPL	Federal Poverty level
ER	Exception Request
HHS	U.S. Department of Health and Human Services
HICP	Health Insurance Continuation Program
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPP	MHN Health Insurance Premium Program
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration (HIV/AIDS Bureau)
HSI	Healthcare Strategic Initiatives
IHS	Indian Health Services
IRS	Internal Revenue Service
LIS	Low Income Subsidy
LTC	Linkage to Care
MHN	MO HealthNet /Medicaid
MIRF	Medical Information Release Form
MO	Missouri
MRT	Medical Review Team
NIH	National Institutes of Health
PBM	Pharmacy Benefits Manager
PLWH	People Living with HIV

PTD	Permanently and Totally Disabled
PWD	People with Disabilities
QMB	Qualified Medicare Beneficiary (QMB) Program
QSM	Quality Service Manager
RW	Ryan White
SBC	Summary of Benefits and Coverage
SCOUT	Securing Client Outcomes Using Technology
SEP	Special Enrollment Period
SLMB	Specified Low-Income Medicare Beneficiary (SLMB) Program
STEP	Successful Transition Exiting Prison
SSD	Social Security Disability
SWS	Statewide Services
TWHA	Ticket to Work Health Assurance Program
TrOOP	Total Out-of-Pocket Costs
VA	Veterans Affairs

Appendix B3

RW Part B and Statewide Services Sliding Fee Scale Fact Sheet

Ryan White Part B and Statewide Services Program
Sliding Fee Fact Sheet

- Ryan White Part B (RWP) and Statewide Services clients will be responsible for a yearly fee based on their yearly family income and size according to federal RWP requirements.
- RWP and Statewide Services client fees are subject to change based on changes in family size and income.
- The following charts show how much each RWP/ADAP client will be charged per year, based on their Federal Poverty Level (FPL):

2024 Federal Poverty Level (FPL) Guidelines

Family Size	85%	100%	200%	250%	300%
1	$12,801	$15,060	$30,120	$37,650	$45,180
2	$17,374	$20,440	$40,880	$51,100	$61,320
3	$21,947	$25,820	$51,640	$64,550	$77,460
4	$26,520	$31,200	$62,400	$78,000	$93,600
5	$31,093	$36,580	$73,160	$91,450	$109,740
6	$35,666	$41,960	$83,920	$104,900	$125,880
7	$40,239	$47,340	$94,680	$118,350	$142,020
8	$44,812	$52,720	$105,440	$131,800	$158,160

For families with more than 8 persons, add $5,380 for each additional person.

Sliding Fee Chart

Household Income:	Sliding Fee Per Year
Less than 100% of FPL	None
101% to 200% of FPL	$1.00
201% to 300% of FPL	$2.00

- RWP and Statewide Services client fees will be due to HSI no later than January 31 of each year.
- **RWP and Statewide Services clients <u>will not</u> be denied HIV related treatment or care, due to their inability to pay their assigned sliding fee.**
- Sliding fee payments may be made by check or money order and must be mailed to:

HSI-NextGen Healthcare
PO Box 1703
St. Peters, MO 63376

- For more information about the sliding fee scale requirement, please see page 26 of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act legislation at https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/about-program/legislation-title-xxvi.pdf

Revised February 2024

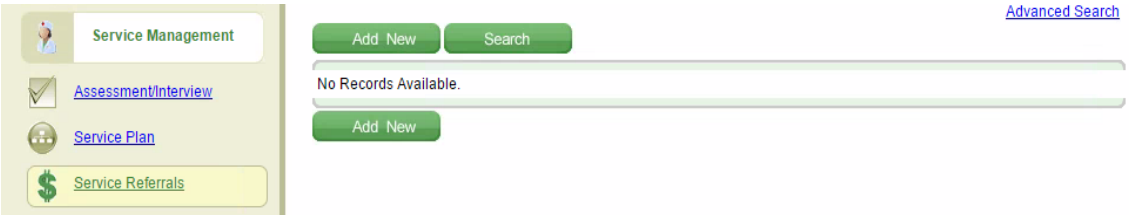
Appendix C1

Statewide Services Data Rule Procedures

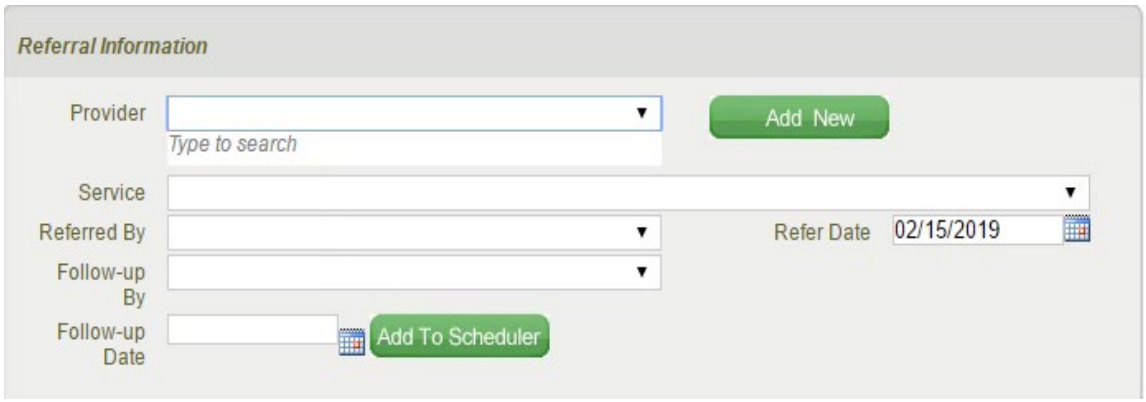
Services Referrals

Clients who are active in MO HIV Case Management or the DES Program could potentially have one or more service referrals for Statewide Services. The HIV CM Data Rules pages 16-18 addresses general steps for how to enter service referrals. Case Managers should complete a new service referral entry for Statewide Services according to pages 16-18 of the HIV CM Data Rules or see the example below.

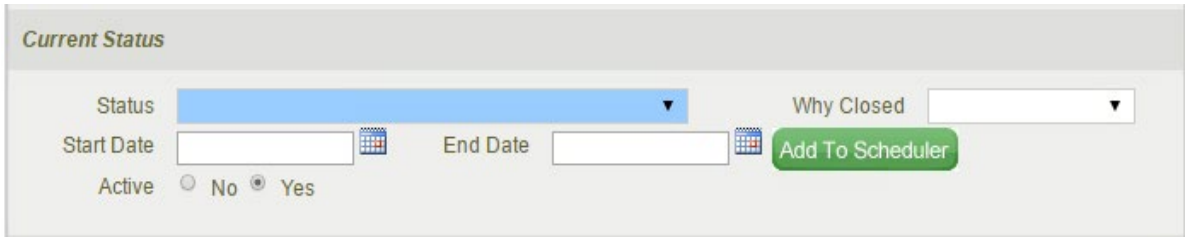
1. Go to the Service Management section and select the "Service Referrals" module.
2. Click on "Add New" to add a new service referral.



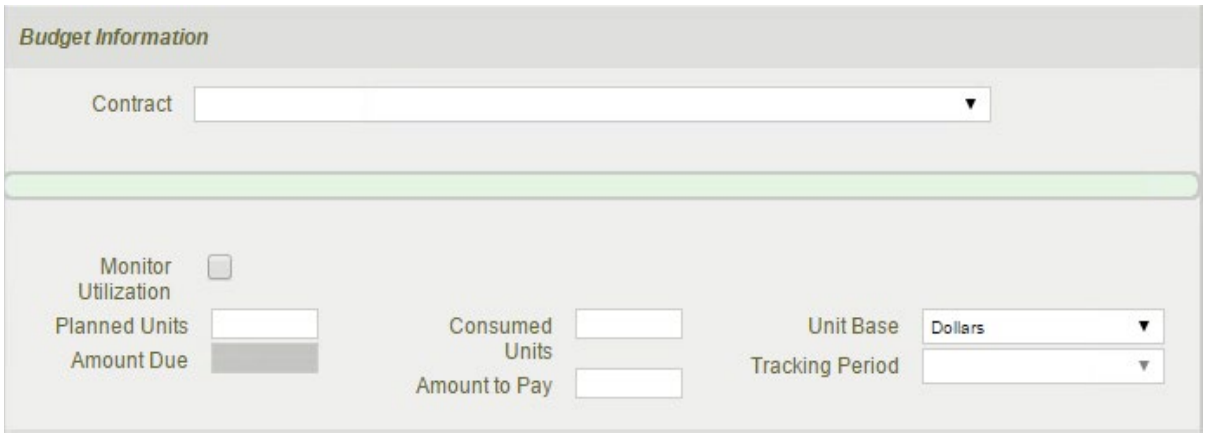
3. Complete the following fields in the "Referral Information" section:
   a. Click on the appropriate provider in the "Provider" field.
   b. Click on the correct service referral option from the "Service" drop-down menu. (SWS Manual Appendix C-2)
   c. Click on your name from the "Referred By" drop-down menu if it does not automatically populate.
   d. Click on the appropriate "Follow-Up By" person from the drop-down menu.
   e. Complete the "Follow-Up Date" field, if needed



4. Complete the "Current Status" section by filling in the following fields:
   a. Click on the "1RFR-Referral Made" option in the "Status" drop-down menu for all Statewide Service referrals.
   b. Complete the "Start Date" field for the first date of client eligibility.



5. The DHSS Benefits Administrator will complete the "Budget Information" section for all Statewide Service referrals. (See screen sample below.)



6. Complete the "Administrative Information" by filling out the following fields:
   a. Click on your agency's name in the "Site" field from the drop-down menu options.
   b. Click on the appropriate region from the drop-down menu options in the "Program" field. (This entry should match the "Region" field to the left.)

7. Click on "Insert".

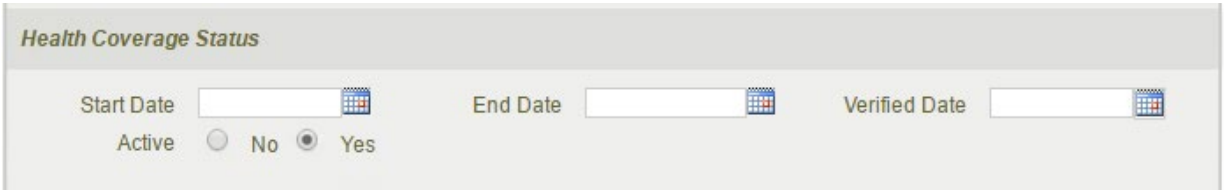
<u>Health Coverage Module</u>

Please follow the steps shown below for completing the "Health Coverage" module according to Statewide Services expectations.

1. Go to the "Financial Module" and click on "Health Coverage".
2. Click on "Add New" to make a new entry.

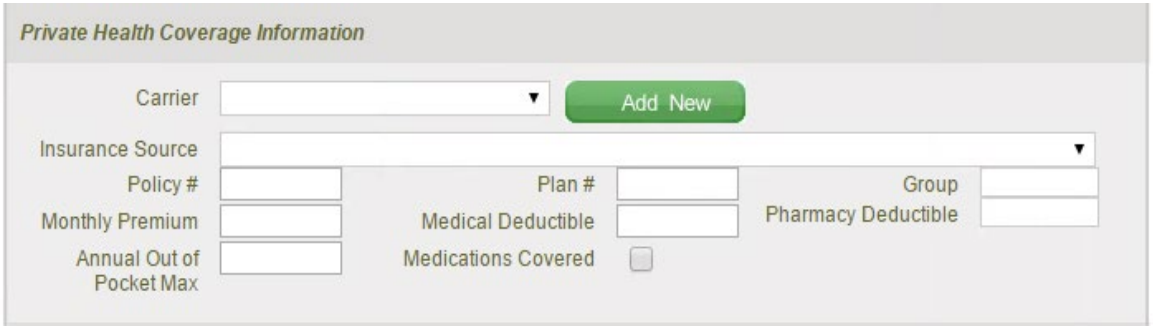
3. Click on "Coverage" and choose from the drop-down menu options.

4. Complete the "Start Date" and "Verified Date" fields.

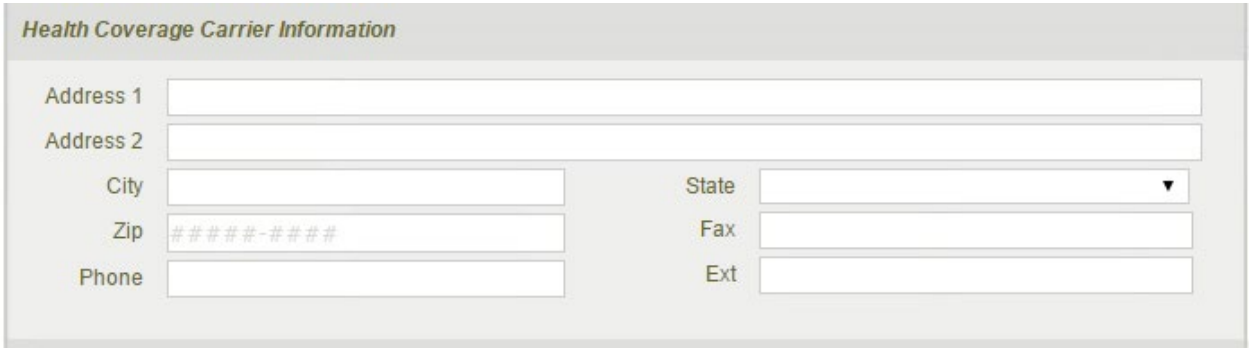


   a. Start Date: Enter the first date the client had active coverage in the current calendar year. If client does not know the first date of coverage, enter the current date.
   b. Verified Date: Enter the date that the coverage was verified by the Case Manager. Case Managers must verify every active health coverage at minimum, one time per calendar year.
   c. Case Managers must include an end date when health insurance terms or changes.
5. Click on the "Active" radial button.
6. Complete the health insurance policy "Holder" information to include the appropriate demographics, if the policy holder is not the client. (HSI does not complete the "Holder" information section if the client is the policy holder.)

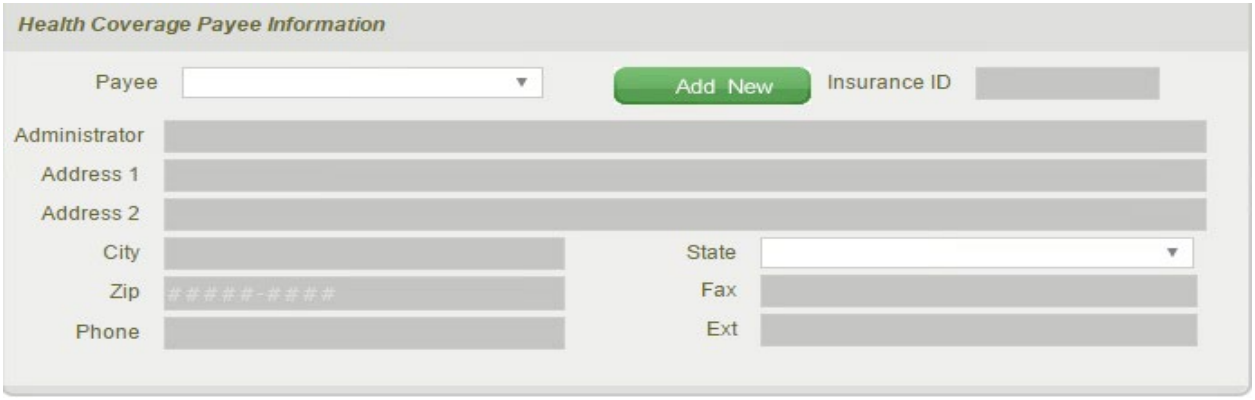
7. HSI will complete the appropriate health insurance provider from the "Carrier" drop-down menu and enter all other available information for "RW PRIV2" entries.
8. HSI will complete the "Insurance Source" information.



9. Complete all available information for the health insurance provider.



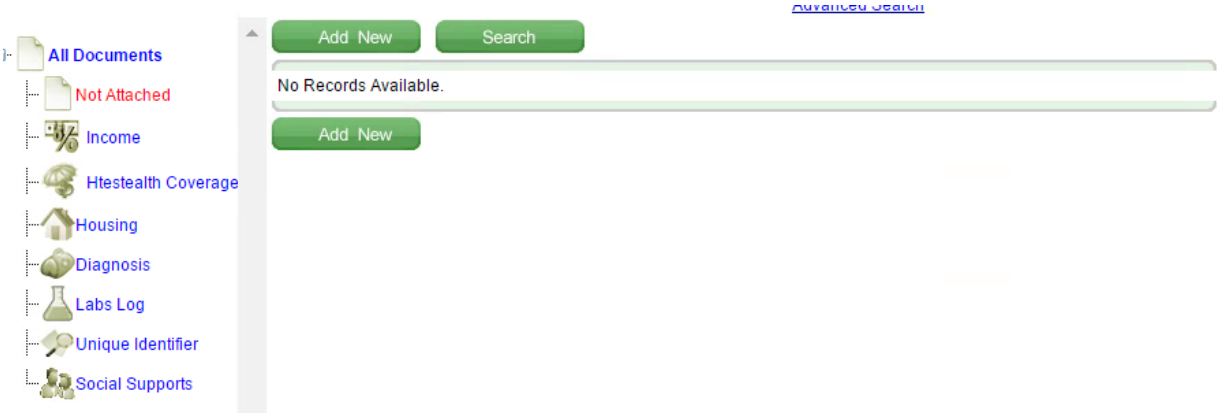
10. Complete all available information for the health insurance provider.



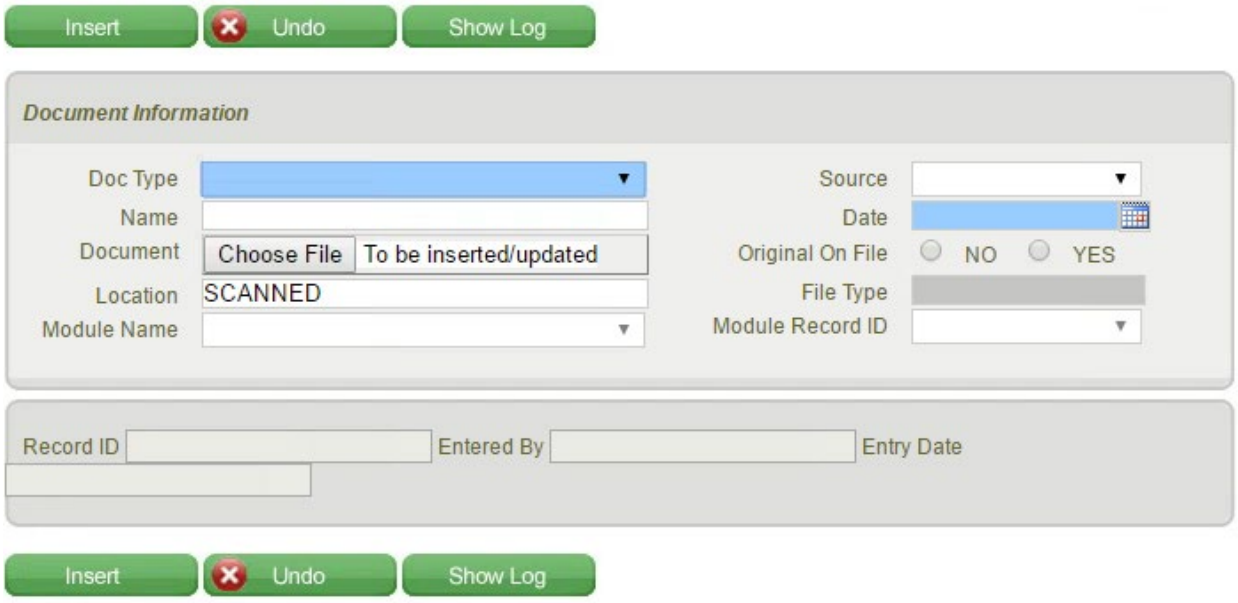
Documents Module

The HIV CM Data Rules pages 11-12 addresses general steps for how to upload documents into the electronic client services database. Upload documents for Statewide Services according to pages 11-12 of the HIV CM Data Rules or see the example below.

1. Go to the Profile Module and click on "Documents".
2. Click on "Add New"



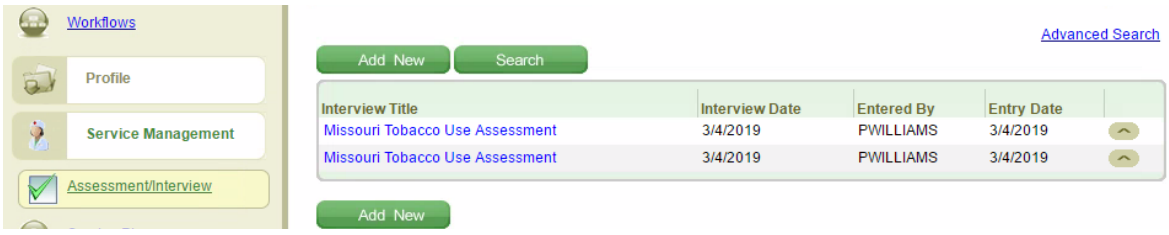
3. Complete the following fields in the "Document Information" section:
    a. Click on the appropriate document type from the "Doc Type" menu options.
    b. Click on the appropriate choice in the "Source" field, if available.
    c. Complete the "Name" field, by giving the document an appropriate name/title.
    d. Complete the "Date" field with the date that the document is uploaded into the electronic client services database.
    e. Click on "Choose File" in the "Document" field. Then search for the appropriate document to be uploaded.
    f. Click on the appropriate radial button for the "Original on File" field.
    g. Click on "Insert"



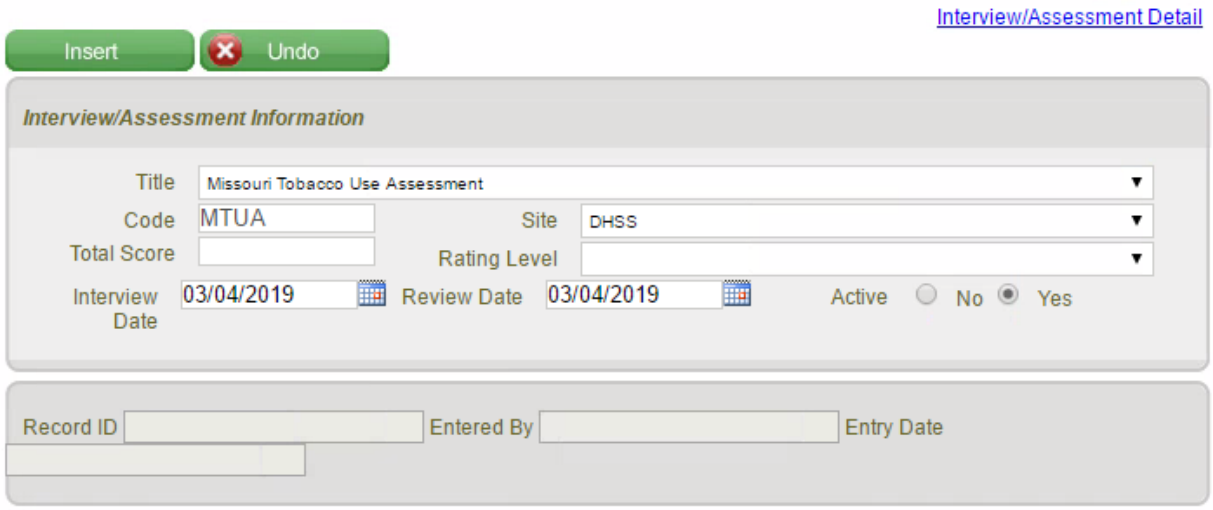
Service Plan Module /Tobacco Assessment

The HIV CM Data Rules pages 15-16 addresses general steps for how to enter assessments for RW clients; however, Case Managers must complete the following steps for the "Tobacco Assessment" to ensure Statewide Services expectations. (SWS Manual Subsection 8.8)

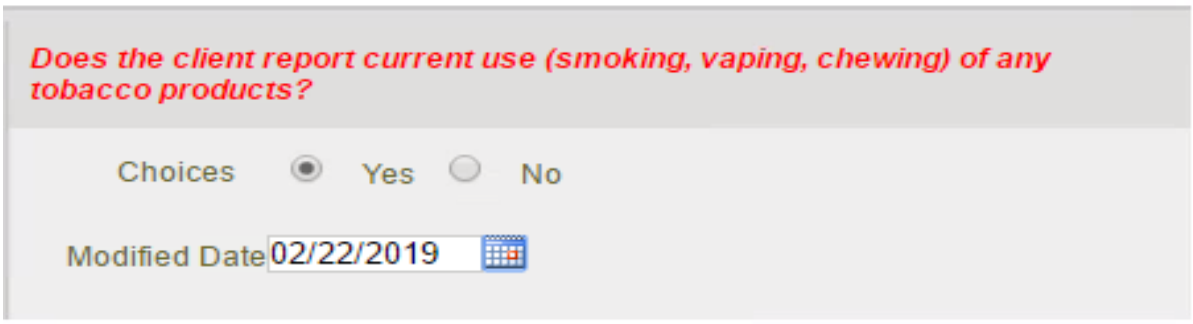
1. Click on the "Service Management" Module.
2. Click on "Add New".



3. Click on the "Missouri Tobacco Use Assessment" from the drop-down menu options.
4. Complete the "Site" information from the drop-down menu options.
5. Complete the "Interview Date".
6. Click on the "Yes" radial button in the "Active" field.
7. Click on "Insert".



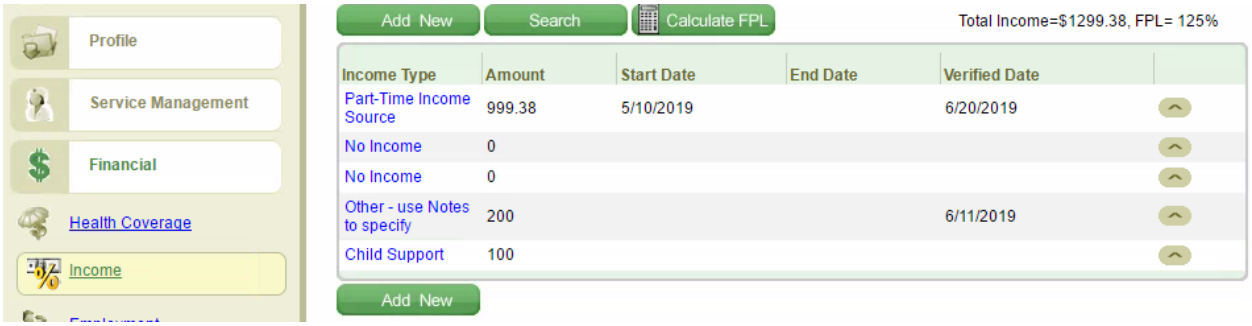
8. Click on the appropriate "Yes" or "No" radial button to answer the tobacco usage question.
9. Complete the "Modified Date" field (modified date= interview date)
10. Click on "Save & Finish".

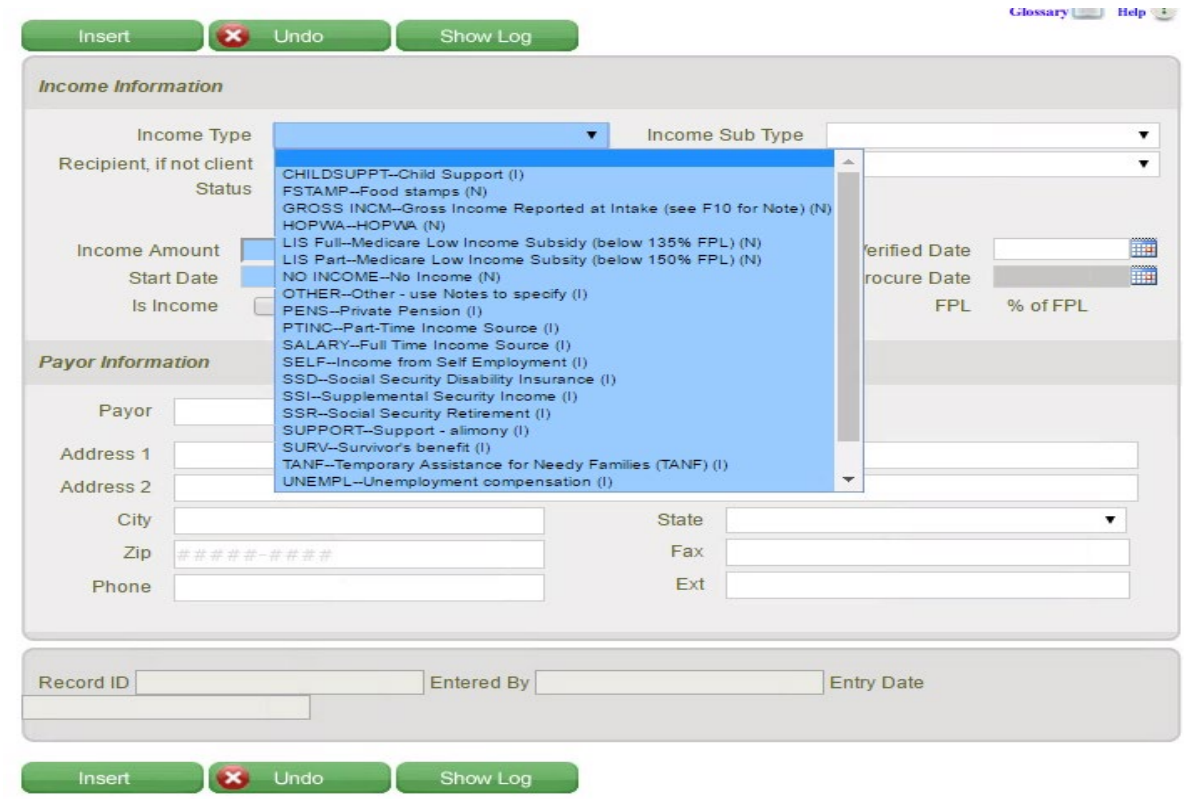


Income Module- Medicare/Low Income Subsidy (LIS)

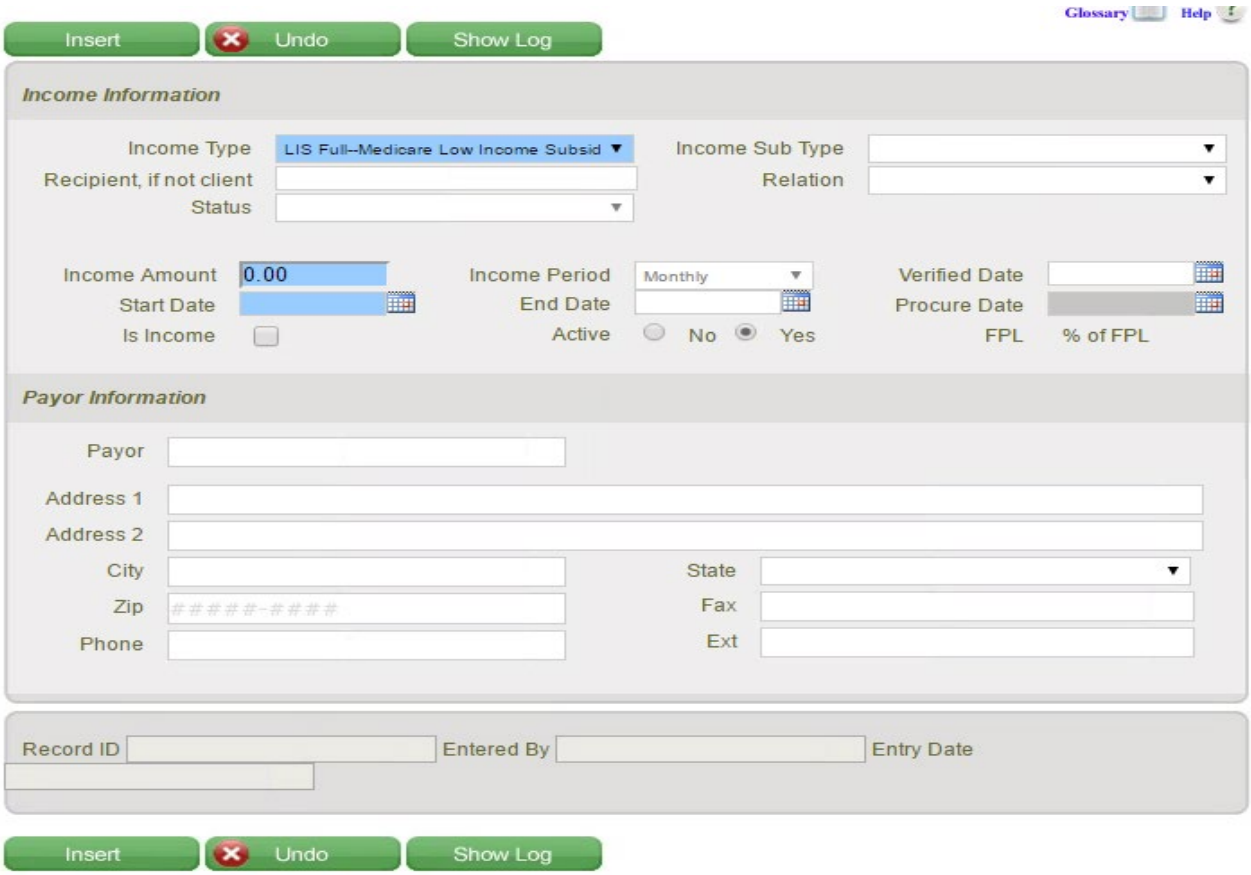
The HIV CM Data Rules pages 23-24 addresses general steps for how to record income for RW clients; however, Case Managers must complete the following steps for the "Medicare/Low Income Subsidy (LIS)" entry to ensure Statewide Services expectations. (SWS Manual Section 5.3)

1. Go to the "Financial" Module and click on "Income".
2. Click on "Add New".





3. Click on one of the two LIS options in the "Income Type" from the drop-down menu:
    a. LIS Full-Medicare Low-Income Subsidy (below 135% FPL) (N) or
    b. LIS Part-Medicare Low Income Subsidy (below 150% FPL) (N)



4. Click on the "Lead Client" option in the drop-down menu in the "Relation" field.
5. Complete the "Income Amount" field by adding $0.00. (This entry should never reflect any other dollar amount.)
6. Complete the "Start Date" if known. If the start date is not known, it should be reflected as the client's interview date.
7. Complete the "End Date" if the client loses the LIS subsidy.
8. Click on "Insert".

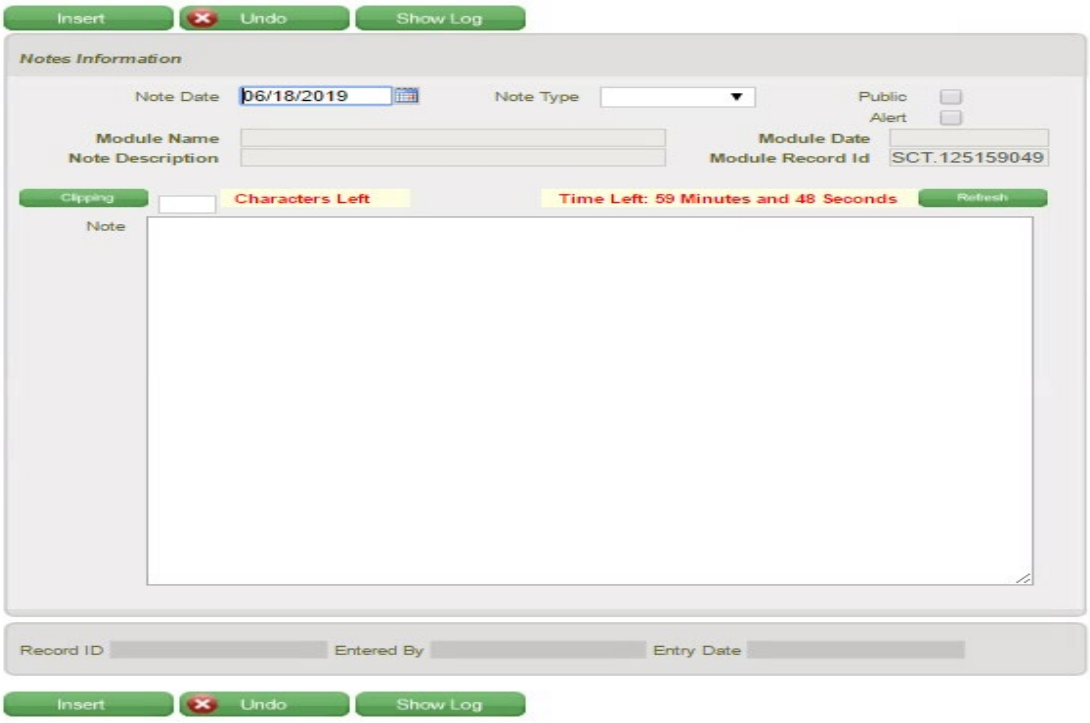
Exception Requests Clippings

The exception request clipping is used to consistently capture information related to requested services, which fall outside of usual Statewide Services policy parameters. Case Managers must complete the following steps for attaching an exception request clipping to appropriate Statewide Service referral(s).

1. Go to the Service Management Module and click on the "Service Referrals" option.
2. Click on the related Statewide Services referral to open the referral

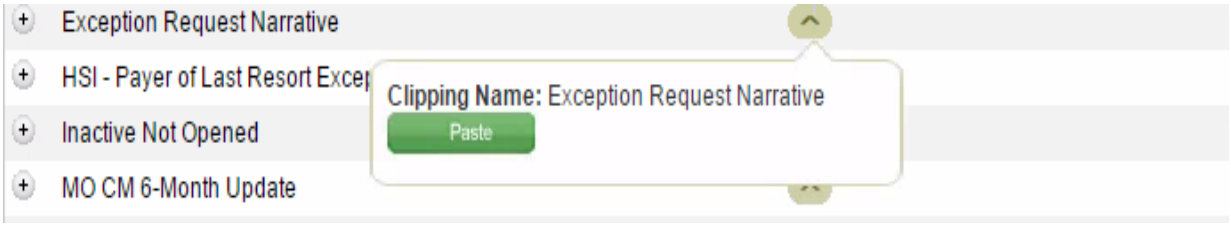
3. Click on "Add New" located at the bottom of the service referral to insert a progress note.

4. Click inside the "Note" field area.
5. Click on "Clipping".



6. Click on the "Exception Request Narrative" clipping to add it to the note pad section.

7. Use the Expand/Collapse function to the left of the screen to review the content of clipping to ensure the correct clipping is being used.
8. Click on the "Up Arrow" located on the right side of the screen.
9. Click on "Paste" to insert the clipping into the client's progress note.



10. Case Managers must include a detailed description as part of the Exception Request explaining all barriers or negative health outcomes that the client may face if the Exception Request is not approved.
11. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
12. Once all information is entered, the Case Manager must change the service referral status to "1EXC".
13. The ADAP Director will send a communicate to the Case Manager if follow-up is needed.
14. If the request is reviewed by the DHSS Benefits Administrator, the service referral status will be changed to "6CSM" if Case Manager follow-up is needed.
15. Case Managers must respond to the ADAP Director's communicate after follow-up has been resolved. If the referral was reviewed by the DHSS Benefits Administrator, the Case Manager should follow-up as needed and change the service referral status to "2SRR".
16. The ADAP Director will submit the referral in "6CSM" to trigger an auto-communicate and immediately change the referral to "2SRR" to alert appropriate staff that a decision has been made regarding the Exception Request.
17. The DHSS Benefits Administrator will change the status to "8ENR" if the request is approved or "9DEN" if the request is denied.

Appendix C2

Statewide Services SCOUT Referral/Encounter Code Matrix

Referral Types	Encounter Types	Health Coverage/Encounter Site
ADAP Program/Medications	R10.4 Medications	Statewide-ADAP
ADAP Program/Medications	R11.C Medications Co-Pay	Statewide-ADAP/HICP
	R11.D Medications Deductible	Statewide-ADAP/HICP
Ambulatory/Outpatient Medical Care Co-Pays	A11.C Primary Care Co-Pay	Statewide-ADAP/HICP
	A11.D Primary Care Deductible	Statewide-ADAP/HICP
Health Insurance Continuation	H40 Health Insurance Premium	Statewide-ADAP/HICP
Spenddown Assistance/Ticket to Work	SPITW - Medicaid Spenddown/ Ticket to Work Assistance	Statewide-ADAP/HICP
STEP	AD10.3 Bus Pass	Client's Region (CE, NW, SE, SW)
Ambulatory/Outpatient Medical Care: Medical Supply Program/ Adult incontinence briefs:	G10.0 Home health	Client's Region (CE, KC, NW, SE, STL, SW)
Case Managers must enter appropriate referrals. The DHSS Benefits Administrator will enter the appropriate encounter type(s).		

Appendix C3

RW Part B and Statewide Services Referral Matrix

Statewide Services Referral Guide				
Program/Client Need	**Region**	**Referral Name**	**Service Description**	**Reference**
Direct Enrollment Services (DES) Program	Statewide	Direct Enrollment Services	Provides financial assistance some services for qualified RW clients without the client being required to be enrolled in MO HIV Case Management.	Statewide Service Manual Policy 8.1
Health Insurance Continuation Program (Premium Payments)	Statewide	HSI-Health Insurance Continuation (HICP)	Payment for HICP approved health insurance plan premiums.	Statewide Service Manual Policy 7.0
Health Insurance Co-Payments	Statewide	HSI-Ambulatory/Outpatient Care Co-Pays	Payment for costs associated with outpatient physician office visits according to current HICP or health insurance plan coverage limitations or exclusions.	Statewide Service Manual Policy 7.0
Medications (primary or secondary)	Statewide	HSI-ADAP Program/Medications	Full payment or co-payment of prescription medication according to current ADAP/HICP or health insurance plan coverage limitations or exclusions.	Statewide Service Manual Policy 6.0 and 7.0
Medicaid Spenddown, Ticket to Work (TWHA) Premiums	Statewide	Spenddown Assistance/Ticket to Work Health Assurance	Monthly payment of MHN Spenddown and TWHA premium payments to ensure access to HIV medication, home health care, etc. through MHN coverage.	Statewide Service Manual Policy 7.4
Successful Transition Exiting Prison Policies and Procedures	Statewide	HSI-STEP	Provides housing and support services to newly released (Jail/Prison) eligible MO Case Managed clients within the first six months after their release date. (Maximum of six months of assistance.)	Statewide Service Manual Policy 8.4
Medical Supply Program	Statewide	HSI-Ambulatory/Outpatient Care/Co-Pays	Provides access to adult incontinence briefs when no other payer sources are available	Statewide Service Manual Policy 8.5

Outstate Services Referral Guide				
Program/Client Need	**Region**	**Referral Name**	**Service Description**	**Reference**
Outpatient Physician Visit (no insurance, no Medicaid, no Medicare)	Outstate/Part B (CE, NW, SE, SW)	HSI-Ambulatory/ Outpatient Medical Care	Provides full payment for outpatient physician visits.	Outstate Services Manual Policy 2.6
Dental	Outstate/Part B (CE, NW, SE, SW)	HSI-Dental	Provides payment of up to $3,000 annually for dental services	Outstate Services Manual Policy 2.6
Deposit Assistance – Rental or Utility	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/RW/Deposit Services	Provides payment for rental or utility deposits.	Outstate Services Manual Policy 3.4.1
Emergency Financial Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Emer.Fin.Asst.-General/Other	Provides payment for some services, which require immediate payment and which may fall outside of the existing service limits or are outside of current established programmatic guidelines.	Outstate Services Manual Policy 6.1
Long-Term Housing Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/Hopwa/Rental Subsidy	Provides payment for long-term housing assistance for clients in need of housing	Outstate Services Manual Policy 3.4.4
Mental Health Treatment	Outstate/Part B (CE, NW, SE, SW)	HSI-Mental Health Counseling	Provides payment for mental health services including office visits, evaluations, and payment for medications.	Outstate Services Manual Policy 2.5
Mortgage Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/Hopwa/Mortage Assistance	Provides payment for temporary assistance for mortgage payments (up to three times annually).	Outstate Services Manual Policy 3.4.3
Substance Abuse Treatment	Outstate/Part B (CE, NW, SE, SW)	HSI-Substance Abuse Treatment Services	Provides payment for substance abuse services including office visits, evaluations, and payment for medications.	Outstate Services Manual Policy 2.6
Short-Term Housing Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/RW/Rental Subsidy	Provides temporary payment assistance for rent (up to three times annually).	Outstate Services Manual Policy 7.4
Transportation	Outstate/Part B (CE, NW, SE, SW)	HSI-Transportation	Provides payment for medical transportation (up to $150.00 per month).	Outstate Services Manual Policy 3.3

Utility Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Utilities	Provides short-term utility assistance (up to three times annually).	Outstate Services Manual Policy 3.4.2
Vision Services	Outstate/Part B (CE, NW, SE, SW)	HSI-Vision	Provides payment for vision services including one office visit and glasses frames and lenses.	Outstate Services Manual Policy 2.4

Appendix C4

Health Insurance Enrollment Related Responsibilities

The following table illustrates the responsible party for ACA and MO Health Net enrollment related duties.

	Client	Case Manager	American Exchange (AE)	HSI	DHSS
ACA Open Enrollment					
Complete the annual ACA/Market Place plan (Pre) Assessment	Yes	Yes	No	No	No
Enroll all eligible clients who do not have other health insurance in ACA/Market Place plans during regular Open Enrollment (November 1-January 15)	No	No	Yes	No	No
Process applications for all potentially eligible MHN clients that **do not** have existing MHN plans during regular Marketplace Open Enrollment AND have not used AE for previous enrollments (only new applicants) (November 1-January 15)	No	No	Yes	No	No
Obtain and submit required Market Place/ACA and MHN documentation. (AE-ONLY new applicants)	Yes	Yes	Yes	No	No
Resolve Marketplace/ACA plan issues by communicating with insurers regarding client policies, when possible	No	No	Yes	Yes	No
ACA Non-Open Enrollment/Special Enrollment Periods					
Enroll all eligible **new or existing** ADAP uninsured clients who do not have other health insurance in ACA/Market Place plans that qualify for Special Enrollment Periods	No	No	Yes	No	No
Resolve Marketplace/ACA plan issues by communicating with insurers regarding client policies, when possible. *Clients are encouraged to resolve plan issues on their own or with the help of their case manager. However, AE and HSI have limited ability to assist if needed for payment-related issues.	Yes	Yes	*Yes	*Yes	No
Reapply for existing MHN Expanded Medicaid coverage by completing required annual MHN updates	Yes	Yes	Yes	No	No
Assist clients with reapplying for MHN coverage by collecting and submitting required MHN enrollment documentation.	Yes	Yes	No	No	No
Alert HSI and AE of income changes which could affect Advanced Personal Tax Credits or MHN eligibility	Yes	Yes	No	No	No

Note: AE may assist with enrolling and re-certifying **NEW** clients into Expanded Medicaid **only** (no other types of MHN) outside of the OE period. Assisting with NEW enrollments will be based on AE discretion. Case Managers may contact AE directly if assistance is needed.

ACA Plan Cancellation Options

1. The client can call the Health Insurance Marketplace and request plan termination at (800) 318-2596.
2. The client can call AE on the Missouri phone line requesting ACA plan termination (844) 357-8779.
3. Case Managers or clients can email AE at mo@americanexchange.com and request plan termination.

Appendix C5

Ryan White (RW) Part B/AIDS Drug Assistance Program (ADAP) Health Insurance Continuation Program (HICP) Limitations and Exclusions

Ryan White (RW) Part B/AIDS Drug Assistance Program (ADAP)
Health Insurance Continuation Program (HICP)
Limitations and Exclusions

- RW Part B/ADAP/HICP cannot pay health insurance premiums for private or public policies, which do not include a pharmacy benefit. (E.g. stand-alone dental or vision insurance policies, etc.)
- Health insurance policies supported by RW Part B/ADAP/HICP must meet program requirements for cost-effectiveness, meet ACA standards for minimum essential benefit coverage and provide adequate access to HIV medications.
- Clients who receive RW Part B/ADAP/HICP assistance with their health insurance premiums are required to use their HSI letter/card for all of their medication pick-ups at the pharmacy level.
- RW Part B/ADAP/HICP assistance is only available if the provider, employer, health insurance plan, etc., are willing to coordinate payment for the employee share of the premium or co-payment with the Department of Health and Senior Services (DHSS) Benefits Administrator (HSI).
- RW Part B/ADAP/HICP clients are required to work within the health insurance plan's limitations, exclusions, and/or restrictions.
- If an individual reaches the maximum level of coverage for an item or service as described in a health insurance plan summary of benefits, RW Part B/ADAP/HICP will not cover additional costs associated with that item or service beyond the health insurance plan maximum.
- RW Part B/ADAP/HICP will not cover co-payments for services if the service is included on the current RW Part B/ADAP exclusion list.
- There is no guarantee that all services will be covered through RW Part B/ADAP/HICP funds, regardless of whether they appear on the Limitation or Exclusion List. Therefore, it is advised that a RW Part B/ADAP/HICP Exception Request for services and supplies, which may be considered questionable for coverage be reviewed by HSI or DHSS prior to accessing the service(s) or supplies.
- RW Part B/ADAP/HICP will not provide coverage for non-antiretroviral medication(s) (including insurance co-payment for medications) that are not included on the most current ADAP formulary.
- Exception requests for non-formulary antiretroviral (ARV) medications must be reviewed and approved by DHSS.
- There is no guarantee that the medication co-payment will be covered through RW Part B/ADAP/HICP funds.
- The RW Part B/ADAP/HICP Limitation or Exclusion List is non-exhaustive and may be modified by DHSS at any time based on current US Public Health Service (PHS) guidelines, Health Resource Service Administration (HRSA) requirements, funding availability, etc.

HICP Premium and Cost Sharing Limitations and Exclusions

Table 1	Type of Coverage and Cost Sharing			
Client Insurance Status	**Premiums**	**Deductibles**	**Co-pays**	**Co-Insurance**
Employer Provided Health Insurance	Yes- if third party payment can be coordinated. The plan formulary must be in accordance with ADAP requirements for cost effectiveness, meet ACA standards for minimum essential benefit coverage and provide adequate access to HIV medications.	Yes- with some RW Part B exclusions.	Yes- with some RW Part B exclusions.	Yes- with some RW Part B exclusions.
Individual Health Insurance	Yes- if third party payment can be coordinated. The plan formulary must be in accordance with ADAP requirements for cost effectiveness, meet ACA standards for minimum essential benefit coverage and provide adequate access to HIV medications.	Yes- with some RW Part B exclusions.	Yes- with some RW Part B exclusions.	Yes- with some RW Part B exclusions.
Oral Health Plan/Riders- Premiums and coverage allowances are not generally considered to be cost effective to ADAP.	No	Yes	Yes	Yes

Table 1 (Continued)	Type of Coverage and Cost Sharing			
Client Insurance Status	**Premiums**	**Deductibles**	**Co-pays**	**Co-Insurance**
Medicare Part A *Per HRSA: ADAP cannot pay premiums or cost sharing on Medicare Part A policies.	No	No	No	No
Medicare Part B **Per HRSA: ADAP can only pay premiums or cost sharing when ADAP is also paying for Medicare Part D premiums or cost sharing.	Yes	Yes	Yes	Yes
Medicare Part C *** ADAP can only pay premiums or cost sharing when Medicare Part C plans include prescription drug coverage, or if ADAP is paying for Medicare Part D premiums and cost sharing for Part C plans that do not include prescription drug coverage.	Yes	Yes	Yes	Yes
Medicare Part D ****Per HRSA: The Medicare Part D plan formulary must be in accordance with ADAP requirements for cost effectiveness and adequate access to HIV medications. *****ADAP spending is counted as part of Medicare Part D's True Out-of-Pocket ("TrOOP") costs.	Yes	Yes- co-pay, deductible, co-insurance as secondary payer prior to and after entering the coverage gap known as TrOOP or the donut hole.	Yes- co-pay, deductible, co-insurance as secondary payer prior to and after entering the coverage gap known as TrOOP or the donut hole.	Yes- co-pay, deductible, co-insurance as secondary payer prior to and after entering the coverage gap known as TrOOP or the donut hole.

Table 1
(Continued)

	Type of Coverage and Cost Sharing			
Client Insurance Status	**Premiums**	**Deductibles**	**Co-pays**	**Co-Insurance**
MO HealthNet (Medicaid) - People with Disabilities Program with a Spenddown	Yes- Coverage for Monthly Spenddown Amount*	No	No	No
MO HealthNet (Medicaid) - People with Disabilities Program with a Spenddown and the Ticket to Work Health Assurance Program (TTW)	Yes- Coverage for Monthly TTW Premium Amount*	No	No	No

Table 2	Service Coverage	
	Outpatient Medical Care	**Other Services**
Employer Provided Health Insurance	Deductibles, co-pays, and co- insurance for services allowed by insurance policy except for RW Part B exclusions.	Deductibles, co-pays, and co-insurance for medication and services allowed by insurance policy except for RW Part B exclusions.
Individual Health Insurance	Deductibles, co-pays, and co- insurance for services allowed by insurance policy except for RW Part B exclusions.	Deductibles, co-pays, and co-insurance for medication and services allowed by insurance policy except for RW Part B exclusions.
Medicare Part B, C	Deductibles, co-pays, and co- insurance for services allowed by insurance policy except for RW Part B exclusions.	Deductibles, co-pays, and co-insurance for medication and services allowed by insurance policy except for RW Part B exclusions.
Medicare Part D	Not applicable	Not applicable
MO HealthNet (Medicaid)- People with Disabilities Program or other MHN health insurance programs	None	None

Note:

- RWHAP funds cannot be used to reimburse clients; therefore, ADAP will only provide assistance for Medicare associated costs, if third-party payment can be coordinated by the client. (HRSA PCN 18-01)
- RW Medicare clients who seek ADAP assistance are expected to pursue the Medicare Low Income Subsidy, if they will likely qualify.
- RW does not provide Medigap related assistance.
- Spenddown payments and TTW premiums must be cost effective to ADAP.
- RW does not support premium assistance for dental or vision insurance riders.
- RW clients who seek ADAP assistance are also expected to pursue MO HealthNet's, Adult Expanded Medicaid, People with Disabilities Program, or other MHN insurance programs if they would likely qualify.

ADAP and HICP Co-Payment and Cost Sharing Product and Service Exclusions

Table 3	The following categories of service are excluded from deductibles, co-pays and/or co-insurance assistance.
23 Hour Observation	No coverage
Acupuncture	No coverage
ADHD	No coverage
Alternative Medicine (includes complimentary therapies, and integrative medicine, etc.)	No coverage
Ambulance Service	No coverage
Assisted and Skilled Nursing Care Facility and Rehabilitation	No coverage
Assisted Fertilization	No coverage
Autism Spectrum Disorders	No coverage
Bariatric Procedures	No coverage
Biofeedback Therapy	No coverage
Chiropractic Services	No coverage
Cleft Palate/Cleft Lip Procedures	No coverage
Corrective Appliances and Durable Medical Equipment (DME) (E.g. eyeglass frames, hearing aids, diabetes monitors, CPAP machines, etc.) ***Outstate Region only:** Please check the Part B Outstate Service Manual for current vision policy and coverages.	No coverage
Cosmetic Procedures (including tattooing, lipodystrophy procedures, etc.)	No coverage
Court Ordered Care	No coverage
Custodial Care	No coverage
Dental Cosmetic Procedures	No coverage
Dermatology	No coverage
Dyslexia	No coverage
Emergency Room and Urgent Care	No coverage

Table 3 (Continued)	**The following categories of service are excluded from deductibles, co-pays and/or co-insurance assistance.**
Employment Related Care	No coverage
Experimental/Investigational Care	No coverage
Genetic Counseling Studies	No coverage
Growth Hormone	No coverage
Hairpiece/Hair Implants	No coverage
Hearing Aids	No coverage
Hemodialysis	No coverage
Home Health Care (including infusion therapy, etc.)	No coverage
Hospice Care	No coverage
Inpatient Care (including inpatient maternity and newborn care, etc.)	No coverage
Medication Pick-Up Medical Office Visit	No coverage
Mental Health Inpatient (Hospital)	No coverage
Physical Therapy	No coverage
Podiatry Services	No coverage
Reversal of Sterilization	No coverage
Sexual Transformation Services/Procedures	No coverage
Sleep Study	No coverage
Spiritual Healing	No coverage
Substance Abuse Inpatient (Hospital)	No coverage
Transplants	No coverage
Treatment Outside the United States	No coverage
Weight Reduction Treatment/Procedures	No coverage, including antidiabetics prescribed for non-diabetics.