

Updated DSHS Policies for AAs and Service Providers

1. Payer of Last Resort (revised/new*)
2. Eligibility (revised)
3. Health Insurance Assistance (extensive revisions/new*)
4. Calculation of Estimated Expenditures
on Covered Clinical Services (new)

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Updated and New Policies

<http://www.dshs.state.tx.us/hivstd/policy/policies.shtm>

- **Payer of Last Resort (PoLR)** Pending public comment, to be posted in Oct. 2015 (590.001)
- **Eligibility to Receive Services** (220.001)
- **Health Insurance Assistance** (260.002)
- **Calculation of Estimated Expenditures on Covered Clinical Services** (270.001)

Payer of Last Resort

- **Screening for Other Payment Sources (7.0)**
 - Providers/Subs must have effective methods for screening clients for health insurance currently held or available including public benefits
- **Vigorously Pursue enrollment**
 - Must document efforts to enroll clients in benefits
 - Clients who refuse to enroll must receive continued counseling on their eligibility at each recertification opportunity or more often if needed

Payer of Last Resort

- **Verification of Coverage (8.0)**
 - Must verify 3rd party coverage for eligible services at every visit
 - **Best Practice** → Providers of 3rd party reimbursable services should have an effective electronic health benefits verification system
- **Client Refusal to Enroll (9.0)**
 - Clients who refuse enrollment may not be refused RW services but may face IRS penalties under the individual mandate

Payer of Last Resort

- **Service Provider Enrollment (10.0)**
- A contracted provider who delivers Medicaid eligible services **must** be enrolled as a Medicaid provider
- Contracted providers that provide services typically covered by health insurance must be included in a broad spectrum of private health plans that PLWHA may enroll in through the Marketplace

Payer of Last Resort

- **Client Charges (11.0)** – Funded agencies that provide OAMC, LPAP/APAP, MH, Medical Nutrition, Home & Community based Services, Home Health, Hospice, EIS and SA treatment services must implement a sliding fee discount program that includes
 1. A Schedule of Fees for services
 2. Corresponding Sliding Fee Discount Schedule
 3. Policy to waive/reduce fees to ensure receipt of care
 4. Policies that prohibit refusal of services if clients refuse or are unable to pay
 5. A limit on annual Aggregate Charges based on the client's household income that applies to all service providers

Payer of Last Resort

- **Program Income (12.0)**
- Income resulting from payments for HIV services by clients or from insurance companies is considered program income. Service providers must retain program income derived from DSHS-funded services and must follow DSHS rules on reporting and use of such income. Providers must also follow any additional requirements of DSHS-funded AAs specified in contract or policy.

Eligibility

- **Policy revised:**
- **Definitions added**
- **Documentation requirements for HIV Infection Status and Texas Residency clarified**
- **Recertification (6 month) requirements clarified**
- **MAGI requirement for financial eligibility added**
- **Reflects advances in Testing Technologies**

Health Insurance Assistance

- **New/revised policy is in effect going into the next Open Enrollment Period**
- **The 2016 Open Enrollment Period is November 1, 2015 to January 31, 2016**
- **If clients don't act by December 15, they will likely be automatically re-enrolled for January 1 – but their premium tax credit will be based on last year's information or on information the Marketplace has from other sources. Clients might be automatically enrolled with no tax credit**

Health Insurance Assistance

- **Is your area/jurisdiction ready for 2016?**
 - **HIA Financial Eligibility criteria set for both Marketplace and COBRA coverage?**
 - **Allocation for HIA sufficient to meet the needs of both new and continuing HIA clients?**
 - **AA and HIA provider policies in place to address**
 - **IRS refunds and “claw-backs” (under/over payment)**
 - **OOP cost sharing expectations for clients over a predetermined income level**
 - **how to handle current HIA clients who may now fall outside of 2016 eligibility guidelines**

Calculation Methodology

- Specifies the methods to be used by DSHS to estimate the aggregate expenditures for covered clinical services in each HSDA
- Planning Councils may use the DSHS estimate or adopt an alternative methodology – DSHS will consider so long as the methodology reasonably estimates per client clinical costs
- DSHS will calculate estimated expenditures in April annually (i.e. next in April 2016)
- Client counts will be based on the most recent calendar year

Calculation Methodology

- Covered clinical expenditures will include OAMC, LPAP and APA, MH services, Home Health, Hospice and inpatient & outpatient Substance Abuse Tx services
- Must include Part B and State Services, and Parts A, C & D when applicable (these data requested on an annual basis for the applicable grantees)
- These amounts will be divided by unique counts of clients receiving one or more of these services
- The statewide per client ADAP expenditure will be added to the estimate of local expenditures on covered clinical services

Technical Assistance

- **What are your area's Technical Assistance needs?**
 - Route comments, questions and requests for TA through your DSHS consultant
- **What expertise can your area offer to other areas?**
 - Sharing best practices and lessons learned
- **Collaborate with other areas to standardize eligibility and enrollment policies & procedures**
 - Ensure equitable access to HIC assistance across the state
 - Ensure overall HIC allocations reflect need
 - Ensure HIC clients who may relocate within Texas do not lose their Health Insurance coverage

Questions/Further Assistance

- **Route your questions, comments and requests for TA to your area's HIV Care Services Consultant**
- **Please freely share your local PoLR, HIA and Eligibility policies & procedures and other related documents with DSHS and other areas**