Michigan Department of Health and Human Services (MDHHS), Health Insurance Premium and Cost Sharing Assistance (HIPCA) Policy and Procedure Guidelines

MDHHS HIV Care Section

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Service Description

Health Insurance Premium and Cost-Sharing Assistance provides financial assistance for eligible consumers with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance.

The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible consumers; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral healthcare services for eligible consumer; and/or
- Paying cost-sharing on behalf of the consumer.

To use Health Resources and Services Administration, Ryan White HIV AIDS Program (HRSA RWHAP) funds for health insurance premium assistance (not standalone dental insurance assistance), a HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Consumers obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services.
- The cost of paying for the health care coverage (including all other sources of premium and cost-sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, a HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost-effective in the aggregate and allocate funding to Health Insurance Premium and Cost-Sharing Assistance only when determined to be cost-effective.

For additional information, please see HRSA Policy Clarification Notice 16-02 and HRSA Policy Clarification Notice 18-01

Michigan Department of Health and Human Services (MDHHS), Health Insurance Premium and Cost Sharing Assistance (HIPCA) Policy & Procedure Guidelines

Purpose

HIPCA provides assistance for Ryan White (RW) Parts A, B, C, D and Care Coordination (CC) consumers based on the need and recommendation of the Case Manager, Supervisor or Director. Sub-recipients and consumers must vigorously pursue and rigorously document other sources of premium and cost-sharing assistance to ensure RW is the Payor of Last Resort.

Policy

Sub-Recipients and consumers must vigorously pursue other sources of premium and cost sharing assistance to ensure RW remains the payor of last resort. Any persons with HIV (PWH) requesting HIPCA payments for insurance premiums, co-pays or laboratory bills should apply for relevant agencies/resources that may be able to assist with coverage or payments. All HIPCA requests must be related to HIV care and treatment.

Payor of Last Resort:
Ryan White funding shall supplement and not supplant existing funds. MDHHS and its funded sub-recipients must assure Ryan White funds are used as a payor of last resort.

Vigorously Pursue and Rigorously Document:
MDHHS and their sub-recipients are expected to vigorously pursue insurance coverage, including Medicaid enrollment, for individuals who are likely eligible for coverage and rigorously document their attempts to enroll their consumer in an insurance plan or Medicaid if the consumer is noncompliant or the attempts are not successful.

Applications are evaluated and considered on a case-by-case basis in scope with RW Standards of Care.

Eligibility and Determination

- Must be HIV-positive.
- Must be a resident of Michigan.
- Must be low income (income not to exceed 500% of the Federal Poverty Level (FPL)).
- Must be underinsured or uninsured for RW services that are reimbursable through third party payors.

Allowable Services

Funds may be used for eligible consumers to receive or maintain health insurance or medical benefits under a health insurance program. This includes out-of-pocket costs such as insurance premium payments, co- payments, coinsurance, and deductibles.

Unallowable Services

- Direct cash payments or cash reimbursements to consumers, including but not limited to third party bills, invoice, statements, i.e. collection services.
- Health insurance plans that do not cover HIV-treatment drugs. Plans must cover at least one drug in each class of core antiretroviral therapeutics from the Health and Human Services (HHS) clinical guidelines as well as appropriate primary care services.
- Medications not listed on the Michigan Drug Assistance (MIDAP) Formulary (unless deemed medically necessary by prescriber). A link to the most updated formulary is listed here along with the MDHHS ScriptGuideRX (SGRX) list of resources: MIDAP Formulary

MDHHS | ScriptGuideRX (SGRX)

- Any cost associated with liability risk pools.
- RWHAP funds cannot be used to cover costs associated with Social Security.
- Funds may not be used to pay fines or tax obligations incurred by consumers for not maintaining health insurance coverage required by the Affordable Care Act (ACA).
- Funds may not be used to make out-of-pocket payments for inpatient hospitalization and/or emergency department care.
- Funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.
- Funds must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage *if a consumer is eligible* for other coverage that provides the required minimal level of coverage at a cost-effective price.

Medical Copays, Coinsurance and Deductibles

HIPCA funds should only be used when the consumer lacks the ability to pay.
If requesting copay, coinsurance or deductible coverage, the following must be provided:

1. Itemized bill from a medical provider showing the insurance adjustment.
2. Date the MIDAP application was submitted and/or denial from MIDAP of the inability to cover the copay, coinsurance or deductible.
3. Services **must be related to HIV Care.**

Dollar Amount Minimum

Agencies are reasonably expected to vigorously pursue and rigorously document resources, funds and services utilized to ensure RWHAP funds are payor of last resort. Please ensure on the HIPCA application to provide all agency denials and attach all supporting documentation. The HIPCA application will only be accepted with requests of a minimum of $10.00.

Timeframe for Requesting HIPCA Assistance

The date of service on the provided invoice must be within one year of submission to HIPCA to be eligible for review. Additionally, the statement date on the invoice must not extend beyond six weeks of submission to HIPCA.

Procedure for Submitting HIPCA Application

Consumers with a Case Manager (CM): If a consumer is assigned to an agency and/or clinic, the agency and/or clinic must submit the HIPCA application online on behalf of the consumer.

1. CM will complete and submit the HIPCA application, including all required supporting documentation, ensuring the following is included:
    a. CAREWare URN#, MIDAP ID and MDP ID.
    b. Consumer is in which funding category: RW Part A, B, C, D, CC, Other. If other, please explain.
    c. Amount Requested & Payment Due Date.
    d. Is this an urgent request?
    e. Date of MIDAP and/or Medicaid application, if applicable.
    f. Name and address of payee.
    g. Patient account number listed on the invoice.
    h. Description of Need: Provide a brief description of need.
    i. How the need relates to the consumer's HIV care.
    j. Agency Denials (e.g., MIDAP, RWB, Medicaid): Agency denials must be provided to ensure the Payor of Last Resort requirement is met.

k. Case Notes must be documented in CAREWare.
l. Case Manager Signature & Date.
m. Supervisor Signature & Date.

2. The following documentation must be submitted with the HIPCA application:
    a. Detailed invoice/itemized bill from the medical provider or insurance company that shows the insurance adjustment and balance due.
    b. The date of service must be within one year of submission to HIPCA to be eligible for review.
    c. The statement date on the bill must be within the six weeks of submission to HIPCA.
    d. Services must be related to the consumer's HIV care. If the information is not evident on the paperwork/invoice as being relevant to the consumer's HIV care, the HIPCA Committee will return the request for additional information. If it is not evident on the paperwork/invoice, the HIPCA committee may request additional information.

HIPCA Application Review Process

1. Submit the HIPCA application with all supporting documentation to MDHHS for review.
2. MDHHS will review the HIPCA request within two weeks of receiving the application.
3. After the HIPCA application has been reviewed, MDHHS will document the approval and/or denial with notes in the CAREWare Case Notes section.
4. After payment has been sent to the vendor, MDHHS will document payment in CAREWare Case Notes section, add the HIPCA service & total amount paid.
5. If the HIPCA application is incomplete or lacking sufficient documentation, MDHHS will document this in the CAREWare Case Notes section. It is the responsibility of the Case Manager to check the CAREWare Case Notes section for all correspondence from MDHHS regarding approvals, denials and/or communication regarding further information needed to complete the HIPCA request.

Sub-recipient Requirements

1. All HIPCA applications and supporting documentation must be kept on file.
2. Documentation of services must be documented in CAREWare by utilizing the MCM or Non- Medical Case Manager (NMCM) support sub-service category.
3. Check CAREWare Case Notes for correspondence from MDHHS regarding status of HIPCA requests.
4. The HIPCA application must be filled out completely and documentation submitted, or additional information may be requested and payment could be delayed.

**** Clinical references and peer reviewed literature to support medical claims as they relate to HIV are highly encouraged.***

Labs

Labs must be related to an HIV care and treatment. Additional documentation may be requested regarding labs if the HIPCA application is lacking sufficient documentation.

Covered Labs:

- Please review the list of labs included in the Outpatient Ambulatory Health Services (OAHS) section of the Michigan Department of Health and Human Services Ryan White Program Service Standards for guidance.

Procedure for Bureau of Laboratories

Below is the process for setting up the MDHHS Bureau of Laboratories MIDAP Testing for HIV Viral Load and CD4/CD8:

Step 1: Set up Testing	Contact the Michigan Drug Assistance Program Coordinator, Shelli Doll at Dolls@michigan.gov. MIDAP will communicate with MDHHS Bureau of Laboratories (BOL), Matt Bashore, for consumer creation, testing supply and education.
Step 2: Consumer Creating for Reporting	The BOL will work with the agency on how they would like to receive their reports. Consumer creation is based on the reporting method chosen below: a. USPS mail: consumer needs to only provide the agency name, address, and phone number. Reports will be sent through USPS mail service. The average turnaround time is 5-7 days. b. Fax transmission: Reports will be automatically faxed to a secure fax number when results are posted. Turnaround time is 2-3 days. c. Electronic Test Order and Reporting (ETOR): Online ordering and reporting.
Step 3: Order Supplies	Supplies are ordered through the MDHHS-BOL Laboratory Kit Order Tracking System LKOTS) https://milkots.michigan.gov/login a. Order Kit #13-CD4/CD8 & Viral Load Testing Kit for HIV-1.
Step 4: Specimen Collection	a. HIV Viral Load – EDTA Preserved Plasma – Ship Cold • Collect in a lavender top EDTA tube. • Spin to separated plasma from red blood cells. • Pour off into polypropylene tubes – label with a unique identifier. • 2 ml plasma is necessary for testing. b. HIV CD4/CD8 – Whole Blood – Room Temperature • Collect in a lavender top EDTA tube. • Label with a unique identifier. • Sample must be tested within 48 hours of draw.

Step 5: Form Completion and Shipping	a. Complete Microbiology/Virology Test Requisition Form DCH – 0583 www.michigan.gov/mdhhslab (one form per patient). b. The form must match the label exactly how it is on the specimen. c. Enter the following on the DCH-0583: • Name and address of the facility submitting the sample. • Agency Code # • Phone and fax number • National Provider Identifier (NPI) • Patient information, including MIDAP ID, date and time of sample collection. • Under **HIV TESTING**: check ☒ CD4/CD8 (EDTA whole blood) and ☒ HIV-1 VIRAL LOAD (EDTA Plasma).

Vaccines

All recommended adult vaccines should be covered by all Michigan local health departments (LHDs). LHDs utilize sliding fee scales for patients that are under/uninsured. Consumers with no insurance or those who have insurance that does not cover routine vaccines, may be charged a sliding scale vaccine administration fee (currently $0-$23 per vaccine) based upon income. Consumers will need to check with the clinic to verify which vaccines qualify for this sliding fee scale. HIPCA can pay for the remaining balance when a case manager submits a completed HIPCA application with all supporting documentation attached.

- For a complete listing of all local health departments, please visit the Michigan Association of Local Public Health (MALPH) here.
- The vaccine requisition form can be found here.

If a consumer receives their vaccine(s) at a location other than the LHD, the case manager must provide justification regarding specific barriers such as transportation, distance/mileage, accessibility, stigma, and discrimination.

Covered Vaccines:

- MMR (measles, mumps, and rubella)
- Tdap (tetanus, diphtheria, and whopping cough)
- Hepatitis A and Hepatitis B
- Shingrix (recombinant Zoster vaccine to prevent Shingles)
- Influenza (annual)
- Pneumonia every five years (age dependent)
- Gardasil 9 (HPV)
- Meningococcal
- COVID-19
- Mpox

Dental

The Michigan Dental Program (MDP) provides dental coverage for PWH that do not have private dental insurance coverage. Consumers may have Medicaid and qualify for MDP.

If requesting dental coverage, the following must be provided:

1. Denial from MDP or copy of private insurance that does not cover dental.
2. Detailed medical bill of services provided.
3. If consumer has insurance and services are not covered 100%, an itemized bill with the insurance adjustment must be submitted.

Dental Services Not Covered:

- Crowns for 3rd Molars. Excluded teeth numbers are 1,16,17, and 32.
- Root canals for 3rd molars. Excluded teeth numbers are 1, 16, 17, and 32.
- Bridges:
  - For lower arch
  - With 4 or more teeth involved
  - Made of porcelain/ ceramic structure
- Periodontal surgery, other than gingivectomy and gingival flap surgery
- Braces
- Implants, and implant services
- Implant crowns or dentures attaching to an implant
- Cosmetic dentistry, including bleaching
- Temporary Dentures
- 2D or 3D X-ray imaging
- Services covered under a hospital, surgical/ medical or prescription drug program
- Treatment of TMJ (temporomandibular joint)
- Inlays and onlays

HIV or Other Related Prescription Copays

HIPCA funds should ONLY be used when the consumer lacks the ability to pay or in emergency situations when MIDAP approval is delayed.

Example: The consumer's deductible has not been met. The consumer can request HIPCA funds to cover the cost of the medication copays. However, the medications must be related to HIV care or be on the MIDAP Formulary.

If requesting medication copays, the following must be provided:

1. Itemized bill from the pharmacy listing all of the medications.
   a. The medication must be related to HIV care and/or is included in the MIDAP Formulary.
2. Insurance adjustments must be listed on the bill from the pharmacy showing what the insurance company paid.
3. Date the MIDAP application was submitted and/or denial from MIDAP of the inability to cover copays or the full cost of the medication.

Health Insurance Premiums

HIPCA funds should only be used for premium assistance when the consumer lacks the ability to pay and is not eligible for MIDAP Premium Assistance. The Premium Assistance Program

through MIDAP assists consumers in paying health insurance premiums. More information can be found in the glossary about this program.

If requesting premium assistance, the following must be provided:

1. Date the MIDAP application was submitted and/or a denial from MIDAP of the inability to cover Premium Assistance at this time.
    a. **COBRA:** a copy of the COBRA election form including the most recent detailed invoice* from the insurance company.
    b. **Medicare Part C:** a copy of the most recent detailed invoice from the insurance company.
    c. **Medicare Part D**: a copy of the most recent detailed invoice from the insurance company.
    d. **Medigap Plan**: a copy of the most recent detailed invoice from the insurance company.
    e. **Qualified Health Plan:** a copy of marketplace eligibility letter and a copy of the most recent detailed invoice from the insurance company.
2. The invoice **must include** the name and address of where the payment needs to be made, total amount due, and patient account number.

Mental Health Services

Please note, RW is the payor of last resort, all mental health resources should be exhausted and explored prior to submitting a HICPA application for mental health services.

- Based on funding availability, ongoing assessments/ justification of the need for mental health services may be requested from the mental health provider.
- Ensure that staff and contracted service providers are mental health professionals currently licensed in Michigan to provide such services (psychiatrists, psychologists, or licensed clinical social workers).

Vision

Documentation of early detection, care, treatment, and prevention of vision problems for eye conditions related to the consumer's HIV status must be provided:

- Co-pays for prescription eyewear: provide a physician's written statement that the eye condition is related to HIV.
- Eye Exam: Standard eye exam every two years with a maximum cost of $150.00.
- Frames and Lenses: Standard frames and lenses are covered every two years.
- Maximum cost for basic frames and standard plastic lenses $200.00.
- Standard plastic poly-carbonite for ages 18 and under only.
- Lenses coverage includes single vision, bifocals, trifocal and UV treatment.

Vision Services Not Covered:

- Cataract surgery
- Contact lenses
- Laser surgery
- Polarized lenses
- Scratch guard

- Standard anti-reflective coating
- Tint

Resources

Vision Resources

Lions Club Provides financial assistance to individuals for eye care through local clubs. http://www.lionsclubs.org/.

New Eyes for the Needy: Purchases basic prescription glasses for people in financial need in the U.S. Telephone: (973) 376-4903. Website: http://www.new-eyes.org/.

Eyecare America: Provides comprehensive eye exams and care for up to one year, often at no out-of- pocket expense to eligible to those 65 and older through its seniors and Diabetes Eye Care Programs. http://eyecareamerica.org.

Michigan 211: Find Help - Michigan 2-1-1 (mi211.org).

Diabetes Resources

American Diabetes Association: Provides assistance for people with diabetes that need help paying or insulin or other diabetes medications https://insulinhelp.org/.

Inside Rx: Discounted prices for several different types of medications http://www.insiderx.com.

Xeris: Assists with the cost of glucagon, may pay as little as zero 1-877-694-8653.

Lilly Cares Foundation: A non-profit organization separate from Lilly that provides insulin for eligible patients. Learn more about the eligibility criteria at www.lillycares.com.

Novo Nordisk Inc.: For $99.00, people with diabetes can get up to three vials or two packs of FlexPen®/FlexTouch®/PenFill® pens, of any combination of Novo Nordisk Inc. insulins with a prescription. 1-844-668-6463.

Prescription Assistance Programs

Partnership for Prescription Assistance Helps people without prescription coverage get medications for free or at a very low cost https://medicineassistancetool.org/.

Rx Assist Comprehensive database of pharmaceutical assistance programs https://www.rxassist.org/.

Rx Hope Helps people get medications for free or for a very small copay https://www.rxhope.com/home.aspx.

GoodRx: Contains a comprehensive database of medications, prices and discounts https://www.goodrx.com/.

Inside Rx: Complete database of medications, prices, and discounts https://insiderx.com/.

Blink Health: Discounted prices for many medications https://www.blinkhealth.com/.

Glossary

Advanced Premium Tax Credit: A tax credit a person can take in advance to lower their monthly health insurance payment or "monthly premium" when they apply for coverage in the Health Insurance Marketplace. When an individual applies for coverage in the Marketplace, they estimate their expected income for the year. If they qualify for a premium tax credit based on that estimate, they can use that amount to lower their monthly premium.

Affordable Care Act/Qualified Health Plan/Marketplace Plan: An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost- sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as "minimum essential coverage." Or more information about the Affordable Care Act or to enroll or update a plan, please visit the Healthcare.gov website.

Balance Billing: This is the balance remaining on a bill that your plan does not cover.

> **Example:** Your provider's charge is $100.00, and the allowed amount is $80.00, the provider may bill you for the remaining $20.00. This most often happens when you see an out-of-network provider.

Coordination of Benefits: If a person has two or more health insurance plans and the insurance companies are trying to figure out who is responsible for paying for the same medical or prescription claim.

Coinsurance: The percentage of health care costs a person is responsible for after they have met their deductible.

> **Example:** A health insurance plan allowed amount for an office visit is $100.00 and your office visit is $20.00:
>
> - If you have paid your deductible: You pay 20% of $100.00, or $20.00 The insurance company pays the rest.
> - If you have not met your deductible: You pay the full allowed amount, $100.00.

Copays: A fixed amount (e.g., $20.00) a person pays for a covered health care service (office visits, lab tests) after their deductible has been met.

Cost-Sharing: The share of costs covered by your insurance that you pay out of your own pocket (sometimes called "out-of-pocket costs"). This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for out-of- network providers, penalties a person may have to pay or the cost of non-covered services. Cost-sharing in Medicaid and CHIP also includes premiums.

Deductible: The amount a person is expected to pay for covered health care services during their coverage period (usually one year) year before their health insurance plan begins to pay.

> **Example:** If your deductible is $1000, your plan will not pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.

Insurance Assistance Program: The Insurance Assistance Program (IAP) assists persons living with HIV maintain their health insurance benefits that are facing financial difficulty by paying health insurance premiums for eligible individuals. For more information, please visit the Insurance Assistance Program website.

Medicaid: Insurance program that provides comprehensive healthcare services to low-income adults, children, pregnant women, the elderly, and people with disabilities.

Medicare Part A (Hospital Insurance): Covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care. For more information, please visit What Part A covers | Medicare.

Medicare Part B (Medical Insurance): Covers doctor and other health care providers' services and outpatient care. Part B also covers durable medical equipment, home health care, and some preventive services. For more information, please visit What Part B covers | Medicare.

Medicare Part C (Medicare Advantage Plan): A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Part C helps cover the cost of medication related copays, deductibles, co-insurance, and insurance premiums. It also includes Medicare Part A, B & D and usually additional services may be included depending on the plan that is chose (vision, hearing, dental). For more information, please visit Medicare Advantage Plans | Medicare.

Medicare Part D (Prescription Plan): A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare. For more information, please visit Drug coverage (Part D) | Medicare.

Medigap Policy (Supplemental Health Insurance): A health insurance policy that is used to fill the "gaps" in Original Medicare Coverage. Medigap policies help pay some of the health care costs that the Original Medicare does not cover. For more information, please visit What's Medicare Supplement Insurance (Medigap)? | Medicare.

Michigan Drug Assistance Program (MIDAP): The Michigan Drug Assistance Program (MIDAP) is a federally funded program that provided HIV-related (and other

related medications) to eligible applicants who have limited or no access to insurance coverage. For more information or to enroll in the program, please visit the MIDAP website.

Open Enrollment: The yearly period when people can enroll in a health insurance plan.

Premiums: The amount a person pays each month towards their health insurance. In addition to a monthly premium, a person must pay for other costs for their health care including a deductible, copays, and coinsurance. If you have a Marketplace plan, you may be able to lower your costs with a premium tax credit.

When shopping for a plan, keep in mind that the plan with the lowest monthly premium may not be the best match for you. A plan with a slightly higher premium but a lower deductible may save you a lot more money.

After you first enroll in a Marketplace plan, you must first pay your premium directly to the insurance company—not to the Marketplace.

Premium Assistance Program: The Premium Assistance (PA) Program helps to cover costs associated with a health insurance policy, including co-payments, deductibles, coinsurance, or premiums to purchase and maintain health insurance coverage. In order to be eligible and enroll in the PA program, a consumer must first be approved for the MIDAP program. The PA program assists eligible consumers pay premiums for:

- COBRA
- Medicare Part C (Advantage Plan)
- Medicare Part D (Prescription Plan) and D
- Affordable Care Act/Qualified Health Plans through the Marketplace

For more information and to enroll in premium assistance, please visit the Premium Assistance Program website.

Special Enrollment Period (SEP): A time outside of the regular yearly Open Enrollment period when a person can sign up for health insurance.

A person may also qualify for a Special Enrollment Period (SEP) if they have had any certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child. Depending on the SEP event, a person may have 60 days before or 60 days following the event to enroll in a plan.