Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds
Policy Clarification Notice (PCN) #16-02 (Revised 12/05/16)
Replaces Policy #10-02

Scope of Coverage: Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN
This policy clarification notice replaces the Health Resources and Services Administration (HRSA) PCN 10-02: Eligible Individuals & Allowable Uses of Funds for Discretely Defined Categories of Services regarding eligible individuals and the description of allowable service categories for Ryan White HIV/AIDS Program and program guidance for implementation.

Background
The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the “Uniform Guidance,” are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of the subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

The HIV/AIDS Bureau (HAB) has developed program policies that incorporate both HHS regulations and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S.
Government Accountability Office may assess and publicly report the extent to which a RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source. At the individual client level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is aggressively and consistently pursued (e.g., Medicaid, CHIP, Medicare, other local or State-funded HIV/AIDS programs, and/or private sector funding, including private insurance).

In every instance, HAB expects that services supported with RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

RWHAP funds are intended to support only the HIV-related needs of eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with RWHAP funds and the intended client’s HIV status, or care-giving relationship to a person with HIV.

Eligible Individuals:

1 See sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.
The principal intent of the RWHAP statute is to provide services to people living with HIV, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HAB expects all RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for RWHAP services in limited situations, but these services for affected individuals must always benefit people living with HIV. Funds awarded under the RWHAP may be used for services to individuals affected with HIV only in the circumstances described below.

a. The service has as its primary purpose enabling the affected individual to participate in the care of someone with HIV or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for someone who is living with HIV.

b. The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a RWHAP client’s portion of a family health insurance policy premium to ensure continuity of insurance coverage for a low-income HIV-infected family member, or child care for children, while an infected parent secures medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member.

Unallowable Costs:
RWHAP funds may not be used to make cash payments to intended clients of RWHAP-funded services. This prohibition includes cash incentives and cash intended as payment for RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,\(^2\) vouchers,

\(^2\) Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the RWHAP are allowable as incentives for eligible program participants.
coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.³

Other unallowable costs include:
- Clothing
- Employment and Employment-Readiness Services
- Funeral and Burial Expenses
- Property Taxes

Allowable Costs:
The following service categories are allowable uses of RWHAP funds. The RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement.

**Service Category Descriptions and Program Guidance**
The following provides both a description of covered service categories and program guidance for RWHAP Part recipient implementation. These service category descriptions apply to the entire RWHAP. However, for some services, the RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a RWHAP Part would cover all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to care for seropositive individuals, retention in care, and the provision of HIV treatment. To be an allowable cost under the RWHAP, all services must relate to HIV diagnosis, care and support, and must adhere to established HIV clinical practice standards consistent with HHS treatment guidelines. In addition, all providers must be appropriately licensed and in compliance with state and local regulations. Recipients are required to work toward the development and adoption of service standards for all RWHAP-funded services.

³ General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are co-branded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.
RWHAP clients must meet income and other eligibility criteria as established by RWHAP Part A, B, C, or D recipients.

**RWHAP Core Medical Services**

- AIDS Drug Assistance Program Treatments
- AIDS Pharmaceutical Assistance
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Home and Community-Based Health Services
- Home Health Care
- Hospice
- Medical Case Management, including Treatment Adherence Services
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient Care

**RWHAP Support Services**

- Child Care Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing
- Legal Services
Linguistic Services
Medical Transportation
Non-Medical Case Management Services
Other Professional Services
Outreach Services
Permanency Planning
Psychosocial Support Services
Referral for Health Care and Support Services
Rehabilitation Services
Respite Care
Substance Abuse Services (residential)

**Effective Date**
This PCN is effective for RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non-competing continuations.

**Summary of Changes**
**August 18, 2016** – Updated *Housing Service* category by removing the prohibition on RWHAP Part C recipients to use RWHAP funds for this service.

**December 12, 2016** – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on RWHAP Parts C and D recipients to use RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.
Appendix

RW HAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments
Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide FDA-approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. RWHAP ADAP recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate.

Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

Program Guidance:
RWHAP Parts A, C and D recipients may contribute RWHAP funds to the Part B ADAP for the purchase of medication and/or health insurance for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B (formerly Title II), AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance; and
PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance
Description:
AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.
1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

RWHAP Part A or B recipients using the LPAP service category must establish the following:
Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary approved by the local advisory committee/board
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state’s RWHAP Part B ADAP
  - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
- Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program

2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

RWHAP Part C or D recipients using this service category must establish the following:
- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV primary care medications not otherwise available to the client
- Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program

Program Guidance:
For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

See Ryan White HIV/AIDS Program Part A and B National Monitoring Standards
See also LPAP Policy Clarification Memo
See also AIDS Drug Assistance Program Treatments and Emergency Financial Assistance
Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- RWHAP Parts A and B EIS services must include the following four components:
  - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
  - Referral services to improve HIV care and treatment services at key points of entry
  - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
  - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- RWHAP Part C EIS services must include the following four components:
  - Counseling individuals with respect to HIV
  - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
    - Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
    - The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources
  - Referral and linkage to care of HIV-infected clients to Outpatient/Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
  - Other clinical and diagnostic services related to HIV diagnosis
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:
Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living 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 clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services.
- RWHAP Part recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health 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.

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

- 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.
**Program Guidance:**

Traditionally, RWHAP Parts A and B recipients have supported health insurance premiums and cost sharing assistance. If a RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

See:

- **PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance**;
- **PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance**;
- **PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid**; and
- **PCN 14-01: Revised 4/3/2015: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act**

**Home and Community-Based Health Services**

*Description:*

Home and Community-Based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client’s needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

**Program Guidance:**

Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

**Home Health Care**

*Description:*

Home Health Care is the provision of services in the home that are appropriate to a client’s needs and are performed by licensed professionals. Services must relate to the client’s HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
• Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:
• Mental health counseling
• Nursing care
• Palliative therapeutics
• Physician services
• Room and board

Program Guidance:
Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:
• Initial assessment of service needs
• Development of a comprehensive, individualized care plan
• Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
• Continuous client monitoring to assess the efficacy of the care plan
• Re-evaluation of the care plan at least every 6 months with adaptations as necessary
• Ongoing assessment of the client’s and other key family members’ needs and personal support systems
• Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
• Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
• Nutrition assessment and screening
• Dietary/nutritional evaluation
• Food and/or nutritional supplements per medical provider’s recommendation
• Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All services performed under this service category must be pursuant to a medical provider’s referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

See Food-Bank/Home Delivered Meals
**Mental Health Services**

*Description:*
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

*Program Guidance:*
Mental Health Services are allowable only for HIV-infected clients.

See Psychosocial Support Services

**Oral Health Care**

*Description:*
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

*Program Guidance:*
None at this time.

**Outpatient/Ambulatory Health Services**

*Description:*
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

*Program Guidance:*
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services
category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

See Policy Notice 13-04: Clarifications Regarding Clients Eligibility for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program
See Early Intervention Services

**Substance Abuse Outpatient Care**

*Description:*
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:
- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

*Program Guidance:*
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

See Substance Abuse Services (residential)

*RWHAP Legislation: Support Services*

**Child Care Services**

*Description:*
The RWHAP supports intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:
- A licensed or registered child care provider to deliver intermittent care
• Informal child care provided by a neighbor, family member, or other person
  (with the understanding that existing federal restrictions prohibit giving cash
to clients or primary caregivers to pay for these services)

*Program Guidance:*
The use of funds under this service category should be limited and carefully
monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which
should be carefully weighed in the decision process.

**Emergency Financial Assistance**

*Description:*
Emergency Financial Assistance provides limited one-time or short-term payments
to assist the RWHAP client with an emergent need for paying for essential utilities,
housing, food (including groceries, and food vouchers), transportation, and
medication. Emergency financial assistance can occur as a direct payment to an
agency or through a voucher program.

*Program Guidance:*
Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency
financial assistance will be effectively used and that any allocation of RWHAP funds
for these purposes will be as the payer of last resort, and for limited amounts, uses,
and periods of time. Continuous provision of an allowable service to a client should
not be funded through emergency financial assistance.

See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance,
and other corresponding categories

**Food Bank/Home Delivered Meals**

*Description:*
Food Bank/Home Delivered Meals refers to the provision of actual food items, hot
meals, or a voucher program to purchase food. This also includes the provision of
essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water
  safety exist

*Program Guidance:*
Unallowable costs include household appliances, pet foods, and other non-essential
products.
See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the RWHAP.

Health Education/Risk Reduction

*Description:* Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients’ partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

*Program Guidance:* Health Education/Risk Reduction services cannot be delivered anonymously.

See Early Intervention Services

Housing

*Description:* Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated annually, to guide the client’s linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:

- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

*Program Guidance:*
RWHAP recipients and subrecipients must have mechanisms in place to allow newly identified clients access to housing services. RWHAP recipients and subrecipients must assess every client’s housing needs at least annually to determine the need for new or additional services. In addition, RWHAP recipients and subrecipients must develop an individualized housing plan for each client receiving housing services and update it annually. RWHAP recipients and subrecipients must provide HAB with a copy of the individualized written housing plan upon request.

RWHAP Part A, B, C, and D recipients, subrecipients, and local decision making planning bodies are strongly encouraged to institute duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients and subrecipients consider using HUD’s definition as their standard.

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.4

Housing services, as described here, replaces the guidance provided in PCN 11-01.

**Legal Services**
See Other Professional Services

**Linguistic Services**
*Description:*
Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

*Program Guidance:*
Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

**Medical Transportation**
*Description:*
Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

*Program Guidance:*
Medical transportation may be provided through:
- Contracts with providers of transportation services

---

4See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.
• Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
• Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
• Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
• Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:
• Direct cash payments or cash reimbursements to clients
• Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
• Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Non-Medical Case Management Services

Description:
Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:
• Initial assessment of service needs
• Development of a comprehensive, individualized care plan
• Continuous client monitoring to assess the efficacy of the care plan
• Re-evaluation of the care plan at least every 6 months with adaptations as necessary
• Ongoing assessment of the client’s and other key family members’ needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

**Other Professional Services**

*Description:*
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills

- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits

*Program Guidance:*
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

*See 45 CFR § 75.459*

**Outreach Services**

*Description:*
Outreach Services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
• Provision of additional information and education on health care coverage options
• Reengagement of people who know their status into Outpatient/Ambulatory Health Services

Program Guidance:
Outreach programs must be:
• Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior
• Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
• Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
• Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection

Funds may not be used to pay for HIV counseling or testing under this service category.

See Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.

See Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:
• Bereavement counseling
• Caregiver/respite support (RWHAP Part D)
• Child abuse and neglect counseling
• HIV support groups
• Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
• Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client’s gym membership.

For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

See Respite Care Services

**Rehabilitation Services**

*Description:*
Rehabilitation Services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client’s quality of life and optimal capacity for self-care.

*Program Guidance:*
Examples of allowable services under this category are physical and occupational therapy.

**Referral for Health Care and Support Services**

*Description:*
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

*Program Guidance:*
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

**Respite Care**

*Description:*
Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

**Program Guidance:**
Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may not be used for off premise social/recreational activities or to pay for a client’s gym membership.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

See Psychosocial Support Services

**Substance Abuse Services (residential)**

**Description:**
Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

**Program Guidance:**
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the RWHAP.

Acupuncture therapy may be allowable funded under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP.
RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.
Clarification of the Ryan White HIV/AIDS Program (RWHAP) Policy on Services Provided to Veterans

Policy Clarification Notice (PCN) #16-01
Replaces Policy #07-07

Scope of Coverage: Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, D, and Part F, where funding supports direct care and treatment services.

Purpose of PCN
This PCN replaces policy notice 07-07: RWHAP recipients may not deny the delivery of RWHAP services, including prescription drugs, to a veteran who is eligible to receive RWHAP services. This PCN also reinforces that the RWHAP is the payer of last resort, so recipients and subrecipients must verify an individual’s eligibility for other private or public programs at the time of initial intake, and routinely thereafter. Lastly, this PCN provides information about RWHAP recipients’ and subrecipients’ ability to enter into agreements with various Department of Veterans Affairs (VA) programs to provide HIV services to RWHAP eligible veterans.

Background
Policy notice 07-07 was developed to provide clear policy guidance to RWHAP recipients and subrecipients regarding the provision of services to clients who are veterans. The PCN also required that all recipients and subrecipients learn more about the VA services made available to veterans in their geographic area. Policy notice 07-07 recognized that many RWHAP recipients and subrecipients have established relationships with VA clinics and providers in proximity to their organizations. The HIV/AIDS Bureau (HAB) continues to require recipients and subrecipients to engage with their local VA providers to ensure RWHAP clients are aware of any services for which they may be eligible, in addition to those offered through RWHAP.
Instructions

Principles Guiding this Policy
By statute, RWHAP funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source. Previous PCNs have provided significant policy guidance on the “payer of last resort” provision, and its impact on RWHAP recipients (See PCN 13-01 and PCN 13-04). Those policies apply with equal force to the VA, however, the VA system differs from other payers because of its unique structure as an integrated care system under which the VA may serve as both payer and provider. Under the VA system, coverage may differ depending on the status of the client, as well as regional differences in availability of services. Furthermore, the VA is not an insurance or entitlement program. The VA encourages veterans to retain any health care coverage they may already have and seek additional health care coverage, when possible.

Requirements and Expectations of Recipients and Subrecipients
RWHAP recipients and subrecipients may not deny services, including prescription drugs, to a veteran who is eligible to receive RWHAP services. RWHAP recipients and subrecipients may not cite the “payer of last resort” language to compel a HIV-infected veteran to obtain services from the VA health care system or refuse to provide services. Services may be refused on the same basis as decisions of refusal for non-veterans. RWHAP recipients and subrecipients must work to assure that veterans receive necessary core medical and support services funded by the RWHAP and/or in the VA system. Available services may vary by geographic location, given both the regional differences across the VA’s system, and variations in local operation of veterans’ facilities. RWHAP recipients and subrecipients are required to become familiar with their local VA care system. RWHAP recipients and subrecipients can provide a valuable service in assisting veterans to establish care within the VA system by becoming familiar with enrollment procedures, eligibility requirements, and local VA contacts for coordination of HIV care, thus ensuring that veterans receive all necessary services to reach optimal health outcomes.

RWHAP recipients and subrecipients may refer eligible veterans to the VA for services, when appropriate and available. However, RWHAP recipients or subrecipients may not require eligible veterans to access medical or supportive services in the VA system nor deny them access to care and support services funded by the RWHAP.

Continuity of care is core to ensuring positive health outcomes for people living with HIV. In instances where RWHAP clients are transitioned from RWHAP providers to VA providers, RWHAP providers will need to work with the VA to ensure coordination of care. Transitioning between providers can result in delays, which can result in interruptions of medical or pharmaceutical care. RWHAP recipients and

1 See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.
subrecipients should work with clients who are veterans to ensure that such gaps in care that jeopardize the veteran’s HIV treatment do not occur and, when necessary, continue to provide RWHAP-funded services during any such transition.

Veterans may also be eligible for services from state-funded veterans’ programs, Veterans Service Organizations, or Vet Centers; RWHAP recipients and subrecipients should be familiar with these other resources.

RWHAP recipients and subrecipients may enter into agreements with various VA programs to provide HIV services to RWHAP eligible veterans. For instance, RWHAP recipients may work with the VA and its contractors to become participating providers under the Patient-Centered Community Care (PC3) program or the VA Veterans Choice Program provider within the VA system. Each of these programs allow for non-VA providers to provide care and services to VA-eligible patients and be reimbursed for those services by the VA. It is incumbent upon the RWHAP recipients and subrecipients to examine these reimbursement program options to determine if either VA program is an appropriate one with which to contract. In some areas, RWHAP recipients may also consider contracting with VA facilities for the VA facilities to provide HIV services to RWHAP clients.
Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income
Policy Clarification Notice (PCN) #15-03
Relates to Policy #15-04

Scope of Coverage
Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, D, and Part F where grants and cooperative agreements support HIV care and treatment services, training, special projects, and related activities that generate program income.

Purpose of PCN
This notice articulates Health Resources and Services Administration (HRSA)/HIV/AIDS Bureau (HAB) policy regarding program income generated and received as a result of the receipt of a RWHAP award. It provides a definition of program income and guidance regarding its use and reporting requirements.

Background
In the context of the RWHAP, program income is most commonly generated by recipients and subrecipients as a result of charging for services and receiving payment from third-party reimbursement. As the Affordable Care Act implementation continues, recipients and subrecipients may generate higher levels of program income. HAB provides this policy clarification notice regarding the use and reporting of program income as it relates to funds awarded through the RWHAP.

Definitions
Program Income: Program income means gross income earned by the non-Federal entity that is directly generated by a supported activity or earned as a result of the Federal award during the period of performance except as
provided on 45 CFR § 75.307(f). Program income includes but is not limited
to income from fees for services performed, the use or rental of [sic.] real or
personal property acquired under Federal awards, the sale of commodities or
items fabricated under a Federal award, license fees and royalties on patents
and copyrights, and principal and interest on loans made with Federal award
funds. Interest earned on advances of Federal funds is not program income.
Except as otherwise provided in Federal statutes, regulation, or the terms
and conditions of the Federal award, **program income does not include
rebates, credits, discounts, and interest earned on any of them.**

**Rebate:** a return of a part of a payment.

**Refund:** an amount of money that is given back to someone who has
returned a product, paid too much, etc.

**Instructions**

**Use of Program Income**

HAB is authorized to consider how program income is to be used and is
authorized to make a distinction between income earned by the recipient
and income earned by subrecipients. HAB has determined that for RWHAP
recipients and subrecipients, the use of program income will be “additive”
(as documented in the Notice of Award). RWHAP Part B recipients may also
use non-Federal program income to meet matching requirements.

Under the “additive” alternative, program income must be used for the
purposes for which the award was made, and may only be used for allowable
costs under the award.

- For Parts A, B, and C, allowable costs are limited to core medical and
  support services, clinical quality management, and administrative
  expenses (including planning and evaluation) as part of a
  comprehensive system of care for low-income individuals living with
  HIV.

---

1 45 CFR § 75.2 (emphasis added).
2 45 CFR § 75.307(e).
3 45 CFR § 75.307(e)(2).
4 45 CFR § 75.307(e)(3). See also section 2617(d)(2)(A) of the Public Health Service (PHS) Act.
5 Sections 2604(a)(2), 2612(a), and 2651(b)(1) of the PHS Act.
• For Part D, allowable costs are limited to family-centered care involving outpatient or ambulatory care, support services, clinical quality management, and administrative expenses for low-income women, infants, children, and youth affected by or living with HIV.  

• For Part F, allowable costs are limited according to the appropriate statutory provision.

• Program income may be utilized for elements of the program that are otherwise limited by statutory provisions, such as administrative and clinical quality management activities that might exceed statutory caps, or unique services that are needed to maintain a comprehensive program approach but that would still be considered allowable under the award.

Under the uniform administrative requirements, to the extent available, recipients and subrecipients must disburse funds available from program income, rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting additional cash payments.

• Recipients and subrecipients should strive to proactively secure and estimate the extent to which program income will be accrued. This should be done to effectively determine the need for RWHAP funds and their allocation and utilization during the current period of performance.

• The statutory exemption from Unobligated Balance (UOB) penalties for Part B recipients that expend rebate dollars before requesting additional grant RWHAP funds does not extend to UOBs accrued as a result of expending program income.

**Documentation and Reporting of Program Income**

Recipients are required to track and account for all program income in accordance with 45 CFR § 75.302(b)(3). Recipients must report program income on their Federal Financial Report (FFRs).

---

6 Sections 2671(a), (b), and (f) of the PHS Act.
7 Sections 2691-2693 of the PHS Act.
8 45 CFR § 75.305(b)(5).
9 For additional information on Rebates, see PCN 15-04.
10 See FFR screenshot:

<table>
<thead>
<tr>
<th>Program Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>l. Total Federal share of program income earned</td>
</tr>
<tr>
<td>m. Program income expended in accordance with the deduction alternative</td>
</tr>
<tr>
<td>n. Program income expended in accordance with the addition alternative</td>
</tr>
<tr>
<td>o. Unexpended program income (line l minus line m or line n)</td>
</tr>
</tbody>
</table>
Additionally, it is the responsibility of the recipient to monitor and track program income earned by subrecipients. Subrecipients should retain program income for “additive” use within their own programs. Consequently, program income earned by subrecipients should not be reported on the recipient’s FFR.

Documentation of program income and accounting for its receipt and utilization will be consistent across Parts, to the extent possible.

a. Parts A and B have a legislatively mandated one-year period of performance and are non-discretionary grants to be awarded each fiscal year.
   i. For Parts A and B, program income for a service provided within one period of performance may be received in the following period.
   ii. Such program income should be accounted for and utilized in the year in which it is received by the program, as the services funded are identical and it is burdensome to revise final FFRs, particularly after a new award has already been issued.
   iii. Program income received at the end of the period of performance will be expended by the recipient prior to the expenditure of new grant RWHAP funds awarded in the subsequent period.

b. Parts C, D, and F are discretionary awards and have multi-year periods of performance.
   i. Parts C, D, and F recipients must account for program income and its use within their multi-year period of performance.
   ii. In the final year of funding, program income received at the end of the period of performance will be expended prior to new grant RWHAP funds awarded in the next competitive cycle, so long as the recipient receives such subsequent award.

11 Insurance refunds must be credited against insurance costs in the year the refund is received pursuant to 45 CFR § 75.447(e).
Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D

Policy Clarification Notice (PCN) #15-01
Supersedes July 17, 2012 Dear RWHAP Part A and Part B Colleagues letter regarding rent as an administrative cost

Scope of Coverage: Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D.

Purpose of PCN
This PCN revises and clarifies the Health Resources and Services Administration’s (HRSA) guidelines for the treatment of costs under the statutory 10% administrative cap for RWHAP Parts A, B, C, and D.

Background
Parts A – D of Title XXVI of the Public Health Service (PHS) Act include a cap that limits the recipient (grantee) costs of administering the award to 10%\(^1\). With a rapidly changing healthcare environment, increasing requirements for oversight of subrecipients (including contractors performing programmatic activities), and required coordination across other federal, state, and local funding streams, RWHAP recipients have new and additional administrative costs. These additional activities coupled with current policies have resulted in unreimbursed administrative costs for RWHAP recipients and less flexibility in the use of HRSA funds to administer their grant(s). In an effort to provide increased flexibility for recipients, within the boundaries of the statute, the HRSA’s HIV/AIDS Bureau (HAB) has re-examined the classification of costs subject to the 10% administrative cost cap.

It is important to note that the additional flexibility with regard to administrative costs will better enable recipients and subrecipients to provide core medical and support services to eligible clients while ensuring that the RWHAP is the payer of last resort.

\(^1\) See §§ 2604(h)(1), 2604(h)(2), 2618(b)(3)(A), 2618(b)(3)(B), 2664(g)(3), and 2671(f)(1) of the PHS Act.

HIV/AIDS BUREAU PCN 15-01
Instructions

Treatment of “Rent” and Other Facilities Costs Incurred to Provide Core Medical and Support Services to Eligible RWHAP Clients

RWHAP Parts A, B, and C Recipients (Grantees)
The portion of indirect and/or direct facilities expenses such as rent, maintenance, and utilities for areas primarily utilized to provide core medical and support services for eligible RWHAP clients (e.g., clinic, pharmacy, food bank, substance abuse treatment facilities) are not required to be included in the 10% administrative cost cap. [See 45 CFR §§ 75.412 – 414, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards for information regarding the classification of costs as direct or indirect.]

RWHAP Parts A and B Subrecipients and Part D Recipients (Grantees)
The portion of direct facilities expenses such as rent, maintenance, and utilities for areas primarily utilized to provide core medical and support services for eligible RWHAP clients (e.g., clinic, pharmacy, food bank, substance abuse treatment facilities) are not required to be included in the 10% administrative cost cap. Note: by legislation, all indirect expenses must be considered administrative expenses subject to the 10% cap.2

Clarifications

For all recipients (grantees) and subrecipients funded by RWHAP Parts A, B, C, or D, the following programmatic costs are not required to be included in the 10% limit on administrative costs; they may be charged to the relevant service category directly associated with such activities:

- Biannual RWHAP client re-certification;
- The portion of malpractice insurance related to RWHAP clinical care;
- The portion of fees and services for electronic medical records maintenance, licensure, and annual updates, and staff time for data entry related to RWHAP clinical care and support services;
- The portion of the clinic receptionist’s time providing direct RWHAP patient services (e.g., scheduling appointments and other intake activities);

2 See §§ 2604(h)(4)(A), 2618(b)(3)(D)(i), and 2671(h)(1) of the PHS Act.

HIV/AIDS BUREAU PCN 15-01
• The portion of medical waste removal and linen services related to the provision of RWHAP services;
• The portion of medical billing staff related to RWHAP services;
• The portion of a supervisor’s time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities, sufficient to assure the delivery of appropriate and high-quality HIV care, to clinicians, case managers, and other individuals providing services to RWHAP clients (would not include general administrative supervision of these individuals); and
• RWHAP clinical quality management (CQM). However, expenses which are clearly administrative in nature cannot be included as CQM costs.

For Parts A, B, and C recipients (grantees)—associated indirect costs may also be charged to the relevant service category.

For all recipients (grantees) funded by RWHAP Parts A, B, C, or D, costs subject to the 10% administrative cap include, but are not limited to:

• Routine grant administration and monitoring activities, including the development of applications and the receipt and disbursal of program funds;
• Development and establishment of reimbursement and accounting systems;
• Preparation of routine programmatic and financial reports;
• Compliance with grant conditions and audit requirements;
• All activities associated with the recipient’s (grantee's) contract award procedures, including the development of requests for proposals, subrecipient and contract proposal review activities, negotiation and awarding of contracts;
• Subrecipient monitoring activities including telephone consultation, written documentation, and onsite visits;
• Reporting on contracts, and funding reallocation activities; and
• Related payroll, audit and general legal services.

\[^3\] See §§ 2604(h)(5)(B)(ii), 2618(b)(3)(E)(ii)(II), and 2664(g)(3) of the PHS Act, which indicate that although CQM is considered an administrative cost, expenses for this activity do not count towards the administrative cost cap. Similarly, § 2671(h)(3)(B) of the PHS Act defines as “services” those services that contribute to or help improve primary care and referral services, and include CQM.

HIV/AIDS BUREAU PCN 15-01
For Part A recipients (grantees), the cost of all activities carried out by the HIV health services planning councils and planning bodies would count toward the 10% administrative cap.\(^4\)

For Part C recipients (grantees), planning and evaluation costs are subject to the 10% administrative cap.

All indirect costs charged by Part D recipients are considered an administrative expense subject to the 10% limit.\(^5\)

**Applicability to Subrecipients**

**RWHAP Parts A and B Subrecipients**

RWHAP Part A and B recipients (grantees) must ensure that the aggregate total of subrecipient administrative expenditures does not exceed 10% of the aggregate total of funds awarded to subrecipients. Subrecipient administrative expenses may be individually set and may vary; however, the aggregate total of subrecipients’ administrative costs may not exceed the 10% limit.

Subrecipient administrative activities include\(^7\)

- usual and recognized overhead activities, **including established indirect rates** for agencies;
- management oversight of specific programs funded under the RWHAP; and
- other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP CQM).

As a reminder: all indirect costs charged by the subrecipient are considered an administrative cost subject to the 10% aggregate limit.

**RWHAP Parts C and D Subrecipients**

The 10% limit on administrative costs does not apply to subrecipients under Parts C and D. RWHAP Parts C and D grantees are responsible for ensuring that subrecipient administrative costs are allowable, reasonable, and allocable to the RWHAP. [See 45 CFR §§ 75.403-405 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards for information regarding basic cost considerations.]

---

\(^4\) See §2604(h)(3)(B) of the PHS Act.

\(^5\) See §2671(h)(1) of the PHS Act.

\(^6\) See §§ 2604(h)(2) and 2618(b)(3)(B) of the PHS Act.

\(^7\) See §§ 2604(h)(4) and 2618(b)(3)(D) of the PHS Act.
Recipient (Grantee) Management and Oversight Functions

RWHAP Parts A, B, C, and D recipients (grantees) are responsible for establishing and maintaining written procedures for allocating and tracking funds applicable to the 10% administrative cost cap in compliance with RWHAP authorizing legislation and the requirements included in 45 CFR part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. Parts A and B recipients are also required to adhere to applicable requirements in the National Monitoring Standards.

If a RWHAP Part A or B recipient (grantee) has contracted with an entity to provide statewide or regional RWHAP management and fiscal oversight (i.e., the entity has entered into a vendor or procurement relationship with the recipient, and is acting on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient’s (grantee’s) 10% administrative cap. Providers that have contracted to provide healthcare services for the lead agency are considered to be first-tier entities (subrecipients) of the grantee and are subject to the aggregate 10% administrative cap for subrecipients.

Effective Date

All of the revisions and clarifications provided in this PCN are effective for RWHAP Parts A, B, C, and D awards issued on or after January 1, 2015. This includes competing continuations, new awards, and non-competing continuations issued on or after January 1, 2015. This PCN does not prevent a recipient (grantee) from adhering to current practice after the effective date. It is up to the recipient to determine how best to meet the needs of eligible RWHAP clients in compliance with RWHAP authorizing legislation, the requirements set forth in 45 CFR part 75, and all terms and conditions of the award.

Recipients (grantees) may not apply changes outlined in this PCN to costs incurred prior to January 1, 2015. Any findings from comprehensive site visits and/or audits related to administrative cost caps before January 1, 2015 remain in effect and will require resolution as documented.
Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

Policy Clarification Notice (PCN) #14-01 Revised 4/3/2015

Scope of Coverage

Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy notice clarifies HRSA policy regarding the use of Ryan White HIV/AIDS Program (RWHAP) funds to purchase health insurance for clients in the Marketplace and the reconciliation of premium tax credits.

Background

As discussed in Policy Clarification Notice (PCN) 13-05 (http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf), many RWHAP clients with incomes between 100-400% of the federal poverty level (FPL) who do not have minimum essential coverage\(^1\) may be eligible for a premium tax credit to offset the cost of purchasing a qualified health plan\(^2\) through the Marketplace.\(^3\) Per PCN 13-05, grantees and subgrantees may use RWHAP funds to pay for any remaining premium amount owed to the health insurance company that is not already covered by the RWHAP client’s premium tax credits. PCN 13-05 also encourages RWHAP grantees and subgrantees to use RWHAP funds for premium

---

1 “Minimum essential coverage” refers to the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes employer-sponsored coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage as defined in Internal Revenue Code Section 5000(a).

2 A qualified health plan is a health insurance plan that is certified by a Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold. See http://www.healthcare.gov/

3 Legal residents with incomes below 100% FPL who have been in the United States for less than five years may also be eligible for advance premium tax credits provided they are not eligible for Medicaid or other minimum essential coverage. See https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.
assistance for clients not eligible for premium tax credits when it is cost-effective, as appropriate and when resources are available.\textsuperscript{4}

When an individual applies for coverage in the Marketplace, the Marketplace will estimate the amount of premium tax credit the individual may claim for the tax year. The amount of the premium tax credit is based on the individual’s income, family size, and the cost of the second-lowest cost silver plan\textsuperscript{5} available to them in the Marketplace. If the Marketplace determines that an individual qualifies for a premium tax credit, the individual may choose to have some or all of the estimated premium tax credit paid in advance directly to the insurance company as an advance payment of the premium tax credit (APTC) to lower the individual’s monthly premium or can wait to get all of the premium tax credit when the individual files a tax return at the end of the year. If the Marketplace determines that an individual does not qualify for a premium tax credit, the individual may still purchase coverage through the Marketplace at the full premium cost.

Individuals who purchased coverage through the Marketplace and received APTCs or plan to claim the premium tax credits at the end of the tax year must file federal income tax returns for that year. This filing requirement applies whether or not the individual would otherwise be required to file a return. Individuals who are married generally must file a joint return to be eligible for the premium tax credit.\textsuperscript{6}

Taxpayers will reconcile any APTC when they file their tax returns. Individuals will subtract the total of any APTC they receive during the year from the amount of the premium tax credit calculated on their tax return (\textit{i.e.}, “actual premium tax credit”) If an individual receives APTC that is less than the actual premium tax credit for which the individual is eligible, the excess amount of premium tax credit will reduce any tax liability of the individual, and may result in a refund. Similarly, if the individual received APTC that exceeds the actual premium tax credit for which the individual is eligible, the individual will owe that amount back to the IRS.

\textsuperscript{4} RWHAP clients not eligible for premium tax credits include clients under 100\% FPL; clients with incomes above 400\% FPL; clients who have minimum essential coverage other than individual market coverage available to them, but choose to purchase in the Marketplace; and clients who are ineligible to purchase insurance through the Marketplace.

\textsuperscript{5} There are four types of coverage that will be offered in each Marketplace: bronze, silver, gold, and platinum. A bronze level qualified health plan (QHP) is a health plan offered in the Marketplace with an actuarial value (AV) of 60\% percent. A silver level QHP has an AV of 70\% percent, a gold level QHP has an AV of 80\% percent, and a platinum QHP has an AV of 90\% percent.

\textsuperscript{6} Clients that are married and file using the filing status Married Filing Separately will not be eligible for the premium tax credit unless they meet the criteria in Notice 2014-23, which allows certain victims of domestic abuse to claim the premium tax credit using the Married Filing Separately filing status for the 2014 calendar year.
Clients initially deemed ineligible for APTC who purchased full-price coverage on the Marketplace may be found eligible for an actual premium tax credit when they file their returns. This could occur because of income fluctuations during the year that result in an annual income that fell within the 100-400% FPL range, or because of changes in family composition that occurred during the year but were not reported to the Marketplace. The resulting premium tax credit will reduce any tax liability of the individual, and may result in a refund, which should be recouped by the grantee or subgrantee if the RWHAP funds were used to pay premiums during the year.


**Importance of Reporting Accurate Information to the Marketplace**

RWHAP grantees and subgrantees should convey to clients the importance of reporting accurate income information on their Marketplace application and reporting to the Marketplace any income or family size changes throughout the year. Notifying the Marketplace about changes in circumstances will decrease the likelihood of a significant difference between the APTC payments (or lack thereof) and the actual premium tax credit. Changes in circumstances that can affect the amount of an individual’s premium tax credit include: increases and decreases in household income, marriage, divorce, birth or adoption of a child, other changes to household composition, and gaining or losing eligibility for government-sponsored or employer-sponsored health care coverage.⁷

**Grantee Expectations for Excess Premium Tax Credits**

As discussed above, it is possible that a RWHAP client’s actual premium tax credit calculated on the tax return is more than the client’s APTC resulting in the client receiving excess premium tax credit either through a reduction in overall tax liability or a refund from the IRS. RWHAP grantees and subgrantees that use program funds to purchase health insurance in the Marketplace must establish appropriate mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS. RWHAP grantees and subgrantees must establish and maintain policies and procedures for the pursuit of excess premium tax credit from individual clients. Grantees and subgrantees must document the steps that were taken to pursue these funds from clients. When establishing such policies, grantees

---

and subgrantees should consider requiring clients to provide a copy of relevant tax forms to determine whether a client received a premium tax credit in excess of the client’s APTC. Recovered excess premium tax credits are considered insurance refunds, not program income. As such, grantees and subgrantees must use recovered excess premium tax credits in the Health Insurance Premium and Cost-sharing Assistance service category in the grant year when the refund is received by the grantee or subgrantee.\textsuperscript{8}

**Grantee Options for Paying for Tax Liabilities Related to APTC**

It is also possible that a RWHAP client’s actual premium tax credit is less than the client’s APTC resulting in the client owing the difference back to the IRS. Had the client’s APTC been calculated to reflect the actual premium tax credit, RWHAP would have been able to pay this difference on the front-end, in the form of higher insurance premiums. Therefore, if grantees choose and if resources are available, they may use RWHAP funds to pay the IRS any additional tax liability a client may owe to the IRS solely based on reconciliation of the premium tax credit. RWHAP grantees should take into consideration their decision to pay such additional tax liability for clients when determining how to operationalize a premium and cost-sharing assistance program in accordance with HAB Policy Clarification Notice 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance. RWHAP grantees and subgrantees are responsible for establishing and maintaining policies and procedures for coordinating such payments to the IRS since RWHAP grantees and subgrantees are prohibited from making any direct payments to clients.\textsuperscript{9} This payment to the IRS must be made from funds available in the year when the tax liability is due, even if the premiums that generated the tax liability were incurred in a previous funding year. However, under no circumstances can RWHAP funds be used to pay the fee (\textit{i.e.}, shared responsibility payment) for a client’s failure to enroll in minimum essential coverage or any other tax liability owed by the client that is not directly attributed to the reconciliation of the premium tax credits.

\textsuperscript{8} See 45 CFR §75.447(e).

\textsuperscript{9} See Sections 2604(i) and 2612(f) of the Public Health Service Act.
Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid
Policy Clarification Notice (PCN) #13-06 (Revised 6/6/2014)
Relates to HAB Policy #’s 10-02 and 7-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN
This policy clarification notice reiterates HRSA policy regarding the use of Ryan White HIV/AIDS Program (RWHAP) for premium and cost-sharing assistance for clients eligible for Medicaid. It also provides RWHAP grantees and subgrantees with additional guidance on using RWHAP funds for premium and cost-sharing assistance in the context of the Affordable Care Act.

Background
Under the Affordable Care Act, beginning January 1, 2014, options for health care coverage for PLWH have been expanded through new private insurance coverage options available through Health Insurance Marketplaces (also referred to as Exchanges) and the expansion of Medicaid in States that choose to expand. Additionally, health insurers will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS. An overview of these health care coverage options may be reviewed at http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf.

By statute, RWHAP funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source.¹ This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

Grantees and subgrantees must also assure that individual clients are enrolled in health care coverage whenever possible or applicable, and informed about the consequences for not enrolling.²

¹ See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

² Under the Affordable Care Act, starting in 2014, if someone can afford it but doesn’t have health insurance coverage in 2014, they may have to pay a fee. See HealthCare.gov, What if someone doesn’t have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014. Under no circumstances may RWHAP funds be used to pay the fee for a client’s failure to enroll in minimum essential coverage.
States that also expand their Medicaid programs may enroll their newly-eligible Medicaid populations into Medicaid managed care plans. The RWHAP will continue to be the payer of last resort and will continue to pay for Ryan White HIV/AIDS Program services not covered, or partially covered, by Medicaid. RWHAP grantees and subgrantees may also consider helping clients pay for premiums and/or cost-sharing, if cost-effective.

**Requirements and Expectations for RWHAP Grantees and Subgrantees**

By statute, RWHAP funds awarded under Parts A, B, and C may be used to support a Health Insurance Premium and Cost-Sharing Assistance Program, a core medical service, for eligible low-income HIV positive clients. Consistent with the RWHAP statute, “low-income” is to be defined by the EMA/TGA, State, or Part C grantee. RWHAP Part D grantees may also use funds to purchase and maintain health insurance, if cost-effective. Therefore, RWHAP funds may be used to cover the cost of Medicaid premiums, deductibles, and co-payments.

If resources are available, Part A planning bodies and Ryan White Part B, C and D grantees may choose to prioritize and allocate funding to Medicaid premium and cost-sharing assistance for low-income individuals in accordance with Section 2615 of the Public Health Service Act. The grantee must determine how to operationalize the Medicaid premium and cost-sharing assistance program, including the methodology used by the grantee to: (1) assure they are buying health coverage that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health coverage option versus paying for the full cost for medications and other appropriate primary care services. The grantee may consider providing the resource allocation to the Part B/AIDS Drug Assistance Program (ADAP) which currently operates the health insurance continuation programs in some States and therefore, have the infrastructure to verify coverage status and process payments to health plans for premiums, co-payments and deductibles, and to pharmacies for medication co-payments and deductibles.

**Requirements and Expectations Specific to Part B AIDS Drug Assistance Program (ADAP)**

ADAP funds may be used to cover costs associated with Medicaid, including co-payments, deductibles, and premiums. In order to use Part B ADAP funds to purchase and maintain health coverage, State ADAPs must be able to document for HRSA/HAB the methodology used by the State to: (1) assure that the health insurance plan, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare

---

3 See Section 2604(c)(3)(F), Section 2612(c)(3)(F), and Section 2651(c)(3)(F) of the Public Health Service Act.
the aggregate cost of paying for the health insurance option versus paying for the full cost for medications.


**RWHAP Premium and Cost-Sharing Assistance and the Affordable Care Act**

The Affordable Care Act increases access to affordable health insurance by establishing a Health Insurance Marketplace in every state where individuals may purchase private health insurance. Many individuals may be eligible for premium tax credits and cost-sharing reductions to help pay for private health insurance offered in the Marketplace. Consequently, RWHAP grantees and subgrantees should take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program, as discussed below. (See also Policy Clarification Notice #13-05, “Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance” http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf).

**Use of RWHAP Funds to Pay for Medicaid Premiums and Cost-Sharing**

Some Medicaid programs may require some beneficiaries to pay premiums, co-payments, and/or deductibles consistent with Medicaid regulations. RWHAP funds can be used to offset any cost-sharing that Medicaid programs may impose on a beneficiary consistent with federal regulations and RWHAP policy.

**Medicaid Premium and Cost-Sharing Assistance for Private Health Plans in the Marketplace**

States can use federal and state Medicaid funds to deliver Medicaid coverage through the purchase of private health insurance. Most commonly, states have used premium assistance to help Medicaid-eligible families pay for available employer-based coverage that the state determines is cost-effective. There are cost-sharing assistance and benefit wrap-around coverage requirements, to the extent that the insurance purchased with Medicaid funds does not meet Medicaid standards. In Medicaid, premium assistance is authorized for group health coverage, and under some authorities, for health plans in the individual market, which, in 2014 would include qualified health plans available through the Marketplace. State Medicaid programs may use premium assistance to enroll a Medicaid eligible individual or family in a qualified health plan through the Marketplace. The premium tax credit is

---

4 See sections 1905(a) and 2105(c) of the Social Security Act.
not available to help cover the cost of a qualified health plan for individuals enrolled using Medicaid funds.

In cases where states elect to use federal and state Medicaid funds towards the purchase of private health insurance, RWHAP funds may not be used to pay for premiums or cost-sharing assistance for private health plans that are paid for or reasonably expected to be paid for by Medicaid. However, RWHAP funds may be used to pay for any remaining premium and/or cost-sharing amounts not covered by Medicaid.

**Conclusion**

Depending on income level, Medicaid-eligible clients may incur some premium expenses and/or cost-sharing depending on the state in which they live. As discussed above, RWHAP funds may be used to cover the cost of Medicaid premiums, deductibles, and co-payments, if applicable. RWHAP grantees and subgrantees should take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program (See also Policy Clarification Notice #13-05, “Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance” http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf ). Grantees and subgrantees are strongly encouraged to work directly with Medicaid to coordinate payment of premiums and cost-sharing for clients.

To learn more about the Affordable Care Act, grantees are encouraged to visit the HIV/AIDS Bureau’s Affordable Care Act website (http://hab.hrsa.gov/affordablecareact/) and HealthCare.gov (http://www.healthcare.gov).

---

5 Section 2615(b)(2) of the Public Health Service Act.
Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance

Policy Clarification Notice (PCN) #13-05 (Revised 6/6/2014)
Relates to HAB Policy #’s 10-02 and 7-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN
This policy clarification notice reiterates HRSA policy regarding the use of Ryan White HIV/AIDS Program (RWHAP) for premium and cost-sharing assistance for the purchase and maintenance of private health insurance coverage. It also provides RWHAP grantees and subgrantees with additional guidance on using RWHAP funds for premium and cost-sharing assistance.

Background
Under the Affordable Care Act, beginning January 1, 2014, options for health care coverage for PLWH have been expanded through new private insurance coverage options available through Health Insurance Marketplaces (also referred to as Exchanges) and the expansion of Medicaid in States that choose to expand. Health insurers also will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS. An overview of these health care coverage options may be reviewed at http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf.

By statute, RWHAP funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source. This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

Grantees and subgrantees must also assure that individual clients are enrolled in health care coverage whenever possible or applicable, and informed about the consequences for not enrolling.2

1 See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

2 Under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage in 2014, they may have to pay a fee. See HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014. Under no circumstances may RWHAP funds be used to pay this fee for a client's failure to enroll in minimum essential coverage.
As Affordable Care Act implementation continues, clients will become eligible for and enroll in qualified health plans offered in the Marketplace. The RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans. RWHAP grantees and subgrantees should consider helping individual clients pay for premiums and/or cost-sharing, if cost-effective.

Requirements and Expectations for RWHAP Grantees and Subgrantees

By statute, RWHAP funds awarded under Parts A, B, and C may be used to support a Health Insurance Premium and Cost-Sharing Assistance Program, a core medical service, for eligible low-income HIV positive clients. Consistent with the RWHAP statute, “low-income” is to be defined by the EMA/TGA, State, or Part C grantee. RWHAP Part D grantees may also use funds to purchase and maintain health insurance, if cost-effective.

RWHAP funds may be used to cover the cost of private health insurance premiums, deductibles, and co-payments to assist eligible low-income clients in maintaining health insurance or receiving medical benefits under a health insurance or benefits program, including high risk pools. However, RWHAP funds may not be used to pay for any administrative costs outside of the premium payment of the health plans or risk pools.

If resources are available, Part A planning bodies and Ryan White Part B, C and D grantees may choose to prioritize and allocate funding to health insurance premium and cost-sharing assistance for low-income individuals in accordance with Section 2615 of the Public Health Service Act. The grantee must determine how to operationalize the health insurance premium and cost-sharing assistance program, including the methodology used by the grantee to: (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate primary care services. The grantee may consider providing the resource allocation to the Part B/AIDS Drug Assistance Program (ADAP) which currently operates the health insurance continuation programs in some States and, therefore, has the infrastructure to verify coverage status and process payments to health plans for premiums, co-payments and deductibles, and to pharmacies for medication co-payments and deductibles.

---

3 See Section 2604(c)(3)(F), Section 2612(c)(3)(F), and Section 2651(c)(3)(F) of the Public Health Service Act.
Requirements and Expectations Specific to Part B AIDS Drug Assistance Program (ADAP)

ADAP funds may be used to cover costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage. In order to use Part B ADAP funds to purchase health insurance, State ADAPs must be able to document for HRSA/HAB the methodology used by the State to: (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications.


RWHAP Premium and Cost-Sharing Assistance and the Affordable Care Act

The Affordable Care Act increases access to affordable health insurance by establishing a Health Insurance Marketplace in every state where individuals may purchase private health insurance. Many individuals may be eligible for premium tax credits and cost-sharing reductions to help pay for private health insurance offered in the Marketplace. Consequently, RWHAP grantees and subgrantees should take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program, as discussed below.

Use of RWHAP Funds for Clients Eligible for Advance Premium Tax Credits

Many RWHAP clients with incomes between 100-400% of the federal poverty level (FPL) without access to certain types of minimum essential coverage\(^4\) may be eligible for premium tax credits to offset the cost of purchasing a qualified health plan\(^5\) through their state’s Marketplace.\(^6\) The amount of the premium tax credit is

---

\(^4\) “Minimum essential coverage” refers to the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes employer-sponsored coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage as defined in Internal Revenue Code Section 5000(a).

\(^5\) A qualified health plan is a health insurance plan that is certified by a Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold. See http://www.healthcare.gov/glossary/g/qhp.html.
based on the individual’s income and the cost of the second-lowest cost silver plan\(^7\) available to them offered in the Marketplace. Once an individual enrolls in a qualified health plan in the Marketplace, the individual can control how much of the projected tax credit is used to help pay the monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the individual’s premium, so the individual pays less out of his/her own pocket.

Grantees and subgrantees may use RWHAP funds to pay for any remaining premium amount owed to the health insurance company that is not already covered by the RWHAP client’s premium tax credits. Grantees and subgrantees should take the following into consideration when operationalizing their health insurance premium and cost-sharing assistance program:

- State-based Marketplaces have flexibility to implement a process for premium payment aggregation. Grantees and subgrantees should work with health insurance issuers and/or the State-based Marketplace to establish a coordinated process that facilitates premium payments by the RWHAP for individual clients.
- In states with a Federally-Facilitated Marketplace, grantees and subgrantees will need to work directly with health insurance issuers to facilitate premium payments by the RWHAP for individual clients.

**Use of RWHAP Funds for Clients Eligible for Cost-Sharing Reductions**

Many RWHAP clients with incomes between 100-250% FPL who receive the advance premium tax credits may also be eligible for additional cost-sharing reductions to lower their out-of-pocket expenses, such as co-payments and deductibles. In order to receive cost-sharing reductions, individuals must receive a premium tax credit and enroll in a silver level plan offered in the Marketplace.

As discussed above, RWHAP funds may only be used to purchase and maintain health insurance that is cost-effective. In determining which qualified health plan in the Marketplace is the most cost-effective for clients eligible for cost-sharing reductions, grantees and subgrantees are encouraged to analyze the formulary adequacy and other essential medical benefits, the cost of the premium, and the effect of any cost-sharing reductions on the overall cost of the qualified health plan. RWHAP grantees and subgrantees should inform clients regarding these analyses to assist RWHAP clients in enrollment decisions.

---

\(^6\) Legal residents with incomes below 100% FPL who have been in the United States for less than five years may also be eligible for advance premium tax credits provided they are not eligible for Medicaid or other minimum essential coverage.

\(^7\) There are four types of coverage that will be offered in each Marketplace: bronze, silver, gold, and platinum. A silver level qualified health plan (QHP) is a health plan offered in the Marketplace with an actuarial value (AV) of 70 percent. A bronze level QHP has an AV of 60 percent, a gold level QHP has an AV of 80 percent, and a platinum QHP has an AV of 90 percent.
Even if an individual is eligible for cost-sharing reductions, he/she may still incur some cost-sharing in his/her health plan. RWHAP funds may be used to cover any remaining costs of co-payments and deductibles if the grantee has established a Health Insurance Premium and Cost-Sharing Assistance Program and be able to document for HRSA/HAB the methodology used to determine if the program is cost-effective.

**Use of RWHAP Funds for Clients Not Eligible for Premium Tax Credits and Cost-Sharing Reductions in a Health Insurance Marketplace**

Grantees and subgrantees should consider that some individuals are ineligible for premium tax credits and cost-sharing reductions:
- Clients under 100% FPL in states that do not implement Medicaid expansion;  
- Clients with incomes above 400% FPL; 
- Clients who have minimum essential coverage other than individual market coverage (e.g., Medicaid, CHIP, TRICARE, employer-sponsored coverage, and certain other coverage defined in Internal Revenue Code Section 5000(a)) available to them, but choose to purchase in the Marketplace; and 
- Clients who are ineligible to purchase insurance through the Marketplace.

If resources are available, RWHAP grantees and subgrantees are strongly encouraged to use RWHAP funds for premium and cost-sharing assistance for these individuals when it is cost-effective, as appropriate. As discussed above, the grantee and subgrantee must ensure that use of RWHAP funds for premium and cost-sharing assistance for these clients is cost-effective.

**Conclusion**

RWHAP funds may be used to help clients purchase and maintain health insurance, if cost-effective and in accordance with RWHAP policy. It is important for grantees and subgrantees to understand the new insurance options available to clients under the Affordable Care Act. Many clients may also be eligible to receive advance premium tax credits and/or cost-sharing reductions to help pay for private health insurance in the Marketplace. RWHAP grantees and subgrantees must take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program. Grantees and subgrantees should also work directly with health insurance issuers and/or the Marketplace to coordinate payment of premiums and cost-sharing for clients.

---

However, please note that legal residents with incomes below 100% FPL who do not qualify for Medicaid or other minimum essential coverage may be eligible for premium tax credits and cost-sharing reductions.

**HIV/AIDS BUREAU POLICY 13-05**
To learn more about the Affordable Care Act, grantees are encouraged to visit the HIV/AIDS Bureau’s Affordable Care Act website (http://hab.hrsa.gov/affordablecareact/) and HealthCare.gov (http://www.healthcare.gov).
Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program

Policy Clarification Notice (PCN) #13-04 (Revised 9/13/2013)
Relates to HAB Policy #13-01, #13-02, #13-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN
This policy notice clarifies HRSA policy regarding the Ryan White HIV/AIDS Program (RWHAP) and its relationship to clients’ eligibility and enrollment in private health insurance.

Background
By statute, RWHAP funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source.¹ This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

The RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans.

This PCN clarifies how the RWHAP payer of last resort requirement applies to clients eligible for private health insurance coverage. Grantees and subgrantees should also refer to Policy Clarification Notice #13-01: Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program (http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf) to understand the RWHAP expectations and requirements for individuals who may be eligible for Medicaid.

¹ See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.
Instructions

Client Eligibility and Enrollment into Private Health Insurance

For policy years beginning on or after January 1, 2014, insurers will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS, and many RWHAP clients may become newly eligible for private health insurance.

Because the RWHAP is the payer of last resort, RWHAP grantees and subgrantees must make every reasonable effort to ensure all uninsured RWHAP clients enroll in any health coverage options for which they may be eligible. This means that grantees and subgrantees are expected to ensure that clients who are determined by the state Medicaid agency and/or the Marketplace to be ineligible for public programs (Medicaid, CHIP, Medicare, etc.) are also assessed for eligibility for private health insurance (e.g., employer-sponsored health plans and health plans offered through the Marketplace).

Under existing guidance, grantees and subgrantees must make every reasonable effort to ensure eligible uninsured RWHAP clients expeditiously enroll in private health insurance plans whenever possible, and inform clients about any consequences for not enrolling. Specifically, RWHAP clients should be informed that under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage, they may have to pay a fee. Some individuals may be exempt from the Affordable Care Act’s requirement to enroll in health coverage. In these circumstances, the Health Insurance Marketplace or the Internal Revenue Service (IRS) will provide individuals with certificates of exemption if they meet certain criteria. RWHAP clients who obtain a certificate of exemption may continue to receive services through the RWHAP. Under no

---

2 To meet the individual responsibility requirement under the Affordable Care Act individuals will need coverage such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE or certain other coverage. See HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014. See also Internal Revenue Service, Questions and Answers on the Individual Shared Responsibility payment Question #5, http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3 Starting January 1, 2014, if someone doesn't have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee that increases every year: from 1% of income (or $95 per adult, whichever is higher) in 2014 to 2.5% of income (or $695 per adult) in 2016. The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. See HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014.

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

Grantees should be aware that clients can only enroll in a private health plan during an open enrollment period, unless they qualify for a special enrollment period based on a qualifying life event, such as moving to a new state, eligibility changes for premium tax credits and/or cost-sharing reductions, or loss of employer-sponsored coverage. If a client misses the open enrollment period and cannot enroll, it is expected that the grantee will make every reasonable effort to ensure the client enrolls into a private health plan upon the next open enrollment period. If a client qualifies for a special enrollment period, it is expected that the grantee will make every effort to ensure the client enrolls in a private health plan before the special enrollment period closes.

HAB will require grantees to maintain policies regarding the required process for the pursuit of enrollment for all clients, to document the steps during their pursuit of enrollment for all clients, and establish stronger monitoring and enforcement of subgrantee processes to ensure that clients are enrolled in coverage options for which they qualify. If after extensive documented efforts on the part of the grantee, the client remains unenrolled in health care coverage, the client may continue to receive services through the RWHAP.

It is also expected that RWHAP grantees collect and maintain documentation verifying client eligibility for other health coverage or a certificate of exemption from the Marketplace or IRS. See Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement (http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf).

**Effective Date of Coverage**

Individuals enrolling in a new private health plan may experience a gap in coverage between submission of their enrollment application and the date on which the health plan will begin to pay for services received by the individual. Generally, payments for items or services will not be made, or cannot reasonably be expected to be made, by the health plan until the effective date of coverage begins. As such, RWHAP funds may be used to pay for items or services up until a client’s effective date of coverage if those items or services are not covered by any other funding source. RWHAP funds may not be used to pay for items or services received on or after the effective date of coverage if they are covered by the client’s insurance plan. In the event that RWHAP-funded services were provided on or after the effective date of coverage, grantees and subgrantees providing those services must

---

5 The initial open enrollment period for the individual Marketplaces will be from October 1, 2013, through March 31, 2014. After the initial open enrollment period, annual open enrollment will occur from October 15 to December 7 every year. See 45 CFR 155.410.

6 See 45 CFR 155.420(d) for more examples of events that may trigger a special enrollment period.
make every reasonable effort to collect payment from the private insurance plan for those RWHAP-funded services.

**Coverage of Services by Ryan White HIV/AIDS Program for Clients Enrolled in Private Health Insurance**

Once a client is enrolled in a private health plan, RWHAP funds may only be used to pay for any Ryan White HIV/AIDS Program services not covered or partially covered by the client’s private health plan.

In addition, RWHAP grantees are strongly encouraged to use RWHAP funds to help clients purchase and maintain health insurance coverage, if cost-effective and in accordance with RWHAP policy. *See Policy Clarification Notice #13-05 Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance* (http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf).

**Health Plan Provider Networks**

RWHAP funds generally may not be used to pay for services that the client receives from a provider that does not belong to the client’s health plan’s network, unless the client is receiving services that could not have been obtained from an in-network provider.

Some health plans may have “tiered” networks that require individuals to pay more to see some providers. As such, providers in any covered tier are not considered “out-of-network.” Grantees and subgrantees are not prohibited from using RWHAP funds to pay for out-of-pocket expenses when the client receives services from a provider in a higher-cost tier, including client out-of-pocket expenses. However, the effect of such payments on available resources should be considered by grantees and subgrantees prior to making such allocations.
**Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post-Implementation of the Affordable Care Act**

Policy Clarification Notice (PCN) #13-03 (Revised 9/13/2013)

**Scope of Policy:** Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

**Summary and Purpose of Policy**
As the Affordable Care Act is implemented, more people living with HIV/AIDS (PLWH) will become eligible for public or private health coverage. This Policy Notice outlines the Ryan White HIV/AIDS Program (RWHAP) expectations for client eligibility determinations in the context of Affordable Care Act implementation. It reviews the new coverage options that will be available to many people living with HIV/AIDS, recommends that RWHAPs standardize RWHAP financial eligibility determinations with the eligibility process for these new coverage options, and reviews RWHAP recertification. The Health Resources and Services Administration, HIV/AIDS Bureau (HRSA/HAB) issued *Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement* ([http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf](http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf)).

**Background**
Under the Affordable Care Act, beginning January 1, 2014, options for health care coverage for PLWH will be expanded through new private insurance coverage options available through the Health Insurance Marketplace (also referred to as the Exchange) and the expansion of Medicaid in states that choose to expand. Additionally, health insurers will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS. An overview of these health care coverage options may be reviewed at [http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf](http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf).

By statute, RWHAP funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source.¹ This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

Grantees and subgrantees must assure that individual clients are enrolled in health care coverage whenever possible or applicable, and are informed about the

¹ See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.
consequences for not enrolling. Please note that the RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans.

**Recommendations**

**RWHAP Eligibility Determination – Affordable Care Act Considerations**

**Modified Adjusted Gross Income (MAGI)**
Grantees should be aware that the Affordable Care Act standardizes and streamlines the methodology for determining financial eligibility for insurance affordability programs. Under the Affordable Care Act, states must use modified-adjusted gross income (MAGI)-based methodologies to make Medicaid and CHIP eligibility determinations for most applicants. The Affordable Care Act streamlines income-counting rules for Medicaid and CHIP and aligns them with rules that will be used in determining eligibility for premium tax credits and cost-sharing reductions for purchasing a qualified health plan through the Health Insurance Marketplace. MAGI-based methodologies must be used regardless of whether a state proceeds with the Medicaid expansion or not.

MAGI is based on federal tax rules for determining adjusted gross income (with some modification). MAGI will be used for most Medicaid/CHIP enrollees, including children, pregnant women, parents, and the new adult group. In most cases, MAGI will not apply to the elderly, individuals with disabilities, those receiving or treated as receiving Supplemental Security Income, and the medically needy. Eligibility determinations for MAGI-excepted groups will be made using current methods. Grantees and subgrantees are encouraged to contact their state Medicaid agency to learn more about how MAGI will be implemented in their state. More information on MAGI-based methodologies can be found at: [http://www.medicaid.gov/State-Resource-Center/Eligibility-Enrollment-Final-Rule/Medicaid-CHIP-Eligibility-and-Enrollment-Webinars.html](http://www.medicaid.gov/State-Resource-Center/Eligibility-Enrollment-Final-Rule/Medicaid-CHIP-Eligibility-and-Enrollment-Webinars.html)

HRSA/HAB strongly encourages RWHAP grantees to consider aligning their RWHAP financial eligibility requirements with the new Affordable Care Act MAGI-based methodologies in order to reduce the burden on clients and to support coordination with the eligibility determination processes for insurance affordability programs.

**Alignment of RWHAP Client Eligibility Determination Processes**
The Affordable Care Act establishes one streamlined application for individuals and families to apply for health coverage through the Marketplace, including insurance affordability programs (premium tax credits and Medicaid/CHIP). The Marketplace

---

2 Under the Affordable Care Act, starting in 2014, if someone can afford it but doesn’t have health insurance coverage in 2014, they may have to pay a fee. See HealthCare.gov, What if someone doesn’t have health insurance?, [https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014](https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014). Under no circumstances may RWHAP funds be used to pay the fee for a client’s failure to enroll in minimum essential coverage.
will also make it easy for consumers to keep their coverage year to year through a simple eligibility redetermination process.

Medicaid eligibility determinations and enrollment will continue to occur at any time throughout the year. Enrollment in qualified health plans offered through the Marketplace will occur during the open enrollment period. Special enrollment periods may be triggered by certain qualifying life events such as moving to a new state, eligibility changes for premium tax credits, or loss of employer-sponsored coverage, etc. Individuals who do not enroll during the open enrollment period will not have another opportunity to enroll in a qualified health plan until the next open enrollment period, unless they experience a qualifying life event that triggers a special enrollment period.

As such, HRSA/HAB strongly encourages RWHAP grantees to consider aligning the RWHAP recertification process with the Marketplace annual eligibility and enrollment processes in order to reduce burden on clients, increase coordination, maximize clients’ enrollment with appropriate insurers, and ensure compliance with payer of last resort requirements. RWHAP grantees and subgrantees must continue to follow the initial eligibility determination and recertifications timelines and documentation requirements in Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement.

Notice of Affordable Care Act Medicaid and/or Marketplace Eligibility Determinations
As individuals apply for different health coverage options, the Marketplace and/or state Medicaid agency will provide them with a timely written notice of their eligibility determination. The Marketplace will also provide individuals with an annual redetermination notice. The RWHAP grantee may consider requiring proof of the Medicaid and/or Marketplace notice of eligibility determination and annual redetermination notice as part of the RWHAP eligibility determination and recertifications processes in order to reduce burden on clients and to allow RWHAP coordination with the Medicaid and/or Marketplace eligibility determination processes. RWHAP grantees and subgrantees must continue to follow the initial eligibility determination and recertifications timelines and documentation requirements in Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement.

Additional Information
Over the coming months, additional information will be released to grantees regarding the Affordable Care Act and the RWHAP and posted at

---

3 The initial open enrollment period for the individual Marketplaces will be from October 1, 2013, through March 31, 2014. After the initial open enrollment period, annual open enrollment will occur from October 15 to December 7 every year. See 45 C.F.R. § 155.410.

4 See 45 C.F.R. 155.420(d) for more examples of events that will trigger a special enrollment period.
http://hab.hrsa.gov/affordablecareact/. In addition, HealthCare.gov (http://www.healthcare.gov) has resources and important information on Affordable Care Act implementation. Please check both websites regularly.
Clarifications on Ryan White Program
Client Eligibility Determinations and Recertifications Requirements

Policy Clarification Notice (PCN) #13-02
Relates to Policy Notice #10-02 and 2011 National Monitoring Standards

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN
This policy clarification outlines the Ryan White HIV/AIDS Program (RWHAP) expectations for client eligibility assessment and clarifies the recertification requirements.

Background
By statute, RWHAP funds may not be used for any item or service “for which payment has been made or can reasonably be expected to be made” by another payment source (Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i) of the Public Health Service (PHS) Act). RWHAP funds may be used to complete coverage that maintains PLWH in care when the individual is either underinsured or uninsured for a specific allowable service, as defined by the RWHAP. Grantees and subgrantees must assure that reasonable efforts are made to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their subgrantees are expected to vigorously pursue eligibility for other funding sources (e.g., Medicaid, CHIP, Medicare, other state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance, etc.) to extend finite RWHAP grant resources to new clients and/or needed services.

Instructions

RWHAP Initial Eligibility Requirements
The RWHAP legislation requires that individuals receiving services through the RWHAP must have a diagnosis of HIV/AIDS and be low-income as defined by the RWHAP grantee. The Health Resources and Services Administration HIV/AIDS Bureau (HRSA/HAB) Policy Notice 10-02 Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services further clarifies that, “[w]hen setting and implementing priorities for the allocation of funds, Grantees, Part A Planning Councils, community planning bodies, and Part B- funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services.” HAB expects all RWHAP grantees to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.
Client Eligibility Recertification

To maintain eligibility for RWHAP services, clients must be recertified at least every six months. The primary purposes of the recertification process are to ensure that an individual’s residency, income, and insurance statuses continue to meet the grantee eligibility requirements and to verify that the RWHAP is the payer of last resort. The recertification process includes checking for the availability of all other third party payers. The HRSA HAB 2011 National Monitoring Standards (NMS) further clarify the RWHAP expectations for assessing client eligibility and recertification. The NMS Section B on Eligibility Determination states that Part A and B grantees must conduct assessment of clients to determine eligibility for RWHAP services within a predetermined time frame and must reassess clients at least every six months to determine continued RWHAP eligibility. Grantees have flexibility with regard to timing and process, especially in consideration of health insurance marketplace enrollment periods, but all grantees across all Parts must engage in eligibility determination and recertification.

It is the expectation of the HIV/AIDS Bureau that at least once a year (whether defined as a 12-month period or calendar year), the recertification procedures include the collection of more in-depth supporting documentation, similar to that collected at the initial eligibility determination.

HAB provides the following clarifications on RWHAP recertification processes expectations:

- Unless otherwise required by State statute, regulations, or policy:
  - Re-verification of HIV diagnosis is not required;
  - Current CD4/viral load documentation is not required by HAB for initial eligibility determination or recertifications, although grantees may choose to collect this for quality management purposes or HAB reporting purposes;
  - Grantees may accept post office boxes as an address, as long as there is another means to verify the address such as a current utility bill or a case manager’s verification letter;
  - At one of the two required recertifications during a year, grantees may accept client self-attestation for verifying that an individual’s income, residency, and insurance status complies with the grantee eligibility requirements. Appropriate documentation is required for changes in status and at least once a year (whether defined as a 12-month period or calendar year).

- RWHAP grantees may utilize recertification data-sharing agreements with other grantees and/or sub-grantees in order to reduce burden on grantees, sub-grantees, and clients.

- If a RWHAP State Part B grantee has developed a multi-tiered and continuous residency, insurance, and income verification review process, that state verification process may satisfy the RWHAP recertification requirement, so
that RWHAP Part B grantees do not have to conduct a separate RWHAP six month recertification process. However, the RWHAP Part B verification processes and supporting documentation must be consistently applied to each individual and available for review either in hard copy or electronically. HAB will consider requests to approve these review processes as the RWHAP six month recertification process on a case-by-case basis and will document approval as appropriate in the Electronic Handbook.

- RWHAP Part C, Part D and Part F grantees where funding supports direct care and treatment services are encouraged to coordinate and streamline eligibility systems and processes with RWHAP Part A and Part B grantees.

### REQUIRED DOCUMENTATION TABLE

<table>
<thead>
<tr>
<th></th>
<th>Initial Eligibility Determination &amp; Once a Year/12 Month Period Recertification</th>
<th>Recertification (minimum of every six months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV Status</strong></td>
<td>Documentation required for Initial Eligibility Determination</td>
<td>No documentation required</td>
</tr>
<tr>
<td></td>
<td>Documentation is not required for the once a year/12 month period recertification</td>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td>Documentation required</td>
<td>Grantee may choose to require a full application and associated documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of no change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of change – grantee must require documentation</td>
</tr>
<tr>
<td><strong>Residency</strong></td>
<td>Documentation required</td>
<td>Grantee may choose to require a full application and associated documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of no change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of change – grantee must require documentation</td>
</tr>
<tr>
<td><strong>Insurance Status</strong></td>
<td>Grantee must verify if the applicant is enrolled in other health coverage and document status in client</td>
<td>Grantee must verify if the applicant is enrolled in other health coverage</td>
</tr>
<tr>
<td></td>
<td>file</td>
<td>Self-attestation of no change</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of change - grantee must require documentation</td>
</tr>
<tr>
<td><strong>CD4/Viral Load</strong></td>
<td>Discretion of grantee</td>
<td>Discretion of grantee</td>
</tr>
</tbody>
</table>

Additional NMS eligibility recertification questions and answers can be found at http://hab.hrsa.gov/manageyourgrant/granteebasics.html.
Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by the Ryan White HIV/AIDS Program

Policy Clarification Notice (PCN) #13-01 (Revised 12/13/2013)

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

By statute, RWHAP funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source.¹ This means grantees must assure that subgrantees make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their subgrantees are expected to vigorously pursue Medicaid enrollment for individuals who are likely eligible for coverage, to seek payment from Medicaid when they provide a Medicaid-covered service for Medicaid beneficiaries, and to back-bill Medicaid for RWHAP-funded services provided for all Medicaid-eligible clients upon determination.²,³ This is a continuation of current program policy, applying both to individuals who are eligible for traditional Medicaid and to those eligible for Alternative Benefit Plans as part of Medicaid expansion.

Instructions

Medicaid-Eligible Clients and the Ryan White HIV/AIDS Program

Currently Uninsured Clients

RWHAP grantees must make every effort to expeditiously enroll individuals in Medicaid if eligible and inform clients about any consequences for not enrolling. Specifically, RWHAP clients should be informed that under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance

¹ See Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.
Some individuals may be exempt from the Affordable Care Act’s requirement to enroll in health coverage. In these circumstances, the Health Insurance Marketplace or the Internal Revenue Service (IRS) will provide individuals with certificates of exemption if they meet certain criteria. RWHAP clients who obtain a certificate of exemption may continue to receive services through the RWHAP. Under no circumstances may RWHAP funds be used to pay the fee for a client’s failure to enroll in minimum essential coverage.

HAB will require grantees to maintain policies regarding the required process for the pursuit of enrollment for all clients, to document the steps during their pursuit of enrollment for all clients, and establish stronger monitoring and enforcement of subgrantee processes to ensure that clients are enrolled in Medicaid if eligible. If after extensive documented efforts on the part of the grantee, the client remains unenrolled in Medicaid, the client may continue to receive services through the RWHAP.

It is also expected that RWHAP grantees collect and maintain documentation verifying client eligibility for Medicaid or a certificate of exemption from the Marketplace or IRS. See Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement (http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf).

Clients Currently Enrolled in a Private Health Insurance Plan

---

4 To meet the individual responsibility requirement under the Affordable Care Act individuals will need coverage such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE or certain other coverage. See HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014. See also Internal Revenue Service, Questions and Answers on the Individual Shared Responsibility payment Question #5, http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

5 Starting January 1, 2014, if someone doesn’t have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee that increases every year: from 1% of income (or $95 per adult, whichever is higher) in 2014 to 2.5% of income (or $695 per adult) in 2016. The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. See HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014.

6 Individuals may be exempt from paying the fee for failing to enroll in minimum essential coverage if they (1) are members of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits and adhere to the tenets of that sect; (2) are members of a recognized health care sharing ministry; (3) are members of a federally recognized Indian tribe; (4) have household income below the minimum threshold for filing a tax return; (5) only went without the required coverage for a short coverage gap of less than three consecutive months during the year; (6) were certified by a Health Insurance Marketplace as having suffered a hardship that makes them unable to obtain coverage; (7) cannot afford coverage because the minimum amount the individual must pay for premiums is more than eight percent of the individual’s household income; (8) are in jail, prison or similar penal institution or correctional facility after the disposition of charges; and (9) are not U.S. citizens, U.S. nationals, or aliens lawfully present in the U.S. See IRS, Questions on Individual Shared Responsibility Provision Question #6, http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.
By law, RWHAP funds may be used to help individuals purchase and maintain health care coverage. Some RWHAP grantees may be currently paying for private health insurance for clients who were determined ineligible for Medicaid in the past. Many of these individuals may become “newly eligible” for Medicaid in states that choose to expand coverage under the Affordable Care Act. Grantees and subgrantees must ensure that they are maximizing RWHAP resources by enrolling clients in a health care coverage option that is more cost-effective than paying the full cost for medications and other essential medical services. RWHAP funds, including AIDS Drug Assistance Program (ADAP) funds, may only be used to continue to pay for private health insurance for Medicaid-eligible clients if it is more cost-effective to do so and in accordance with RWHAP policy. See Policy Clarification Notice #13-05: Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance (http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf).

**Coverage of Services by the Ryan White HIV/AIDS Program**

Once an individual is enrolled in Medicaid, RWHAP funds may be used to pay for any medically necessary services which Medicaid does not cover or only partially covers, as well as premiums, co-pays, and deductibles if required. RWHAP funds will continue to cover other core medical services such as adult dental, vision, or enhanced adherence and prevention counseling services as part of primary care if those services are not covered or are partially covered under Medicaid, even when those services are provided at the same visit as Medicaid-covered services.

**Effective Date of Coverage**

Medicaid coverage may start retroactively for up to 3 months prior to the month of application, if the individual would have been eligible during the retroactive period had he or she applied then.⁷ RWHAP services received between the retroactive date of coverage and the date the client is enrolled in Medicaid will need to be back-billed and reimbursed to the RWHAP.

---

⁷ See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html.

Dear Part A and Part B Ryan White HIV/AIDS Program Grantees:

Part A and B funds awarded under the Ryan White HIV/AIDS Program are subject to unobligated balances (UOB) provisions contained in Title XXVI of the Public Health Service (PHS) Act. The Health Resources Services Administration’s (HRSA) HIV/AIDS Bureau (HAB) provides the enclosed Policy Notice 12-02 regarding UOB provisions and how they relate to permissible carryover of grant funds per statute.

Moreover, Policy Notice 12-02 explains the UOB requirements and potential penalties imposed on grantees that do not comply with the requirements contained in sections 2603(c) and 2622 of the PHS Act, Timeframe for Obligation and Expenditure of Grant Funds effective September 30, 2009. Prior Policy Notice 10-01 has been revised to clarify the required time-frame for the reporting and use of UOB and the interaction between UOB and carryover.

This is a deviation from the language reflected in the Funding Opportunity Announcements (FOA) Part A HIV Emergency Relief Grant Program: HRSA-12-128, and Part B State/Territories Formula & AIDS Drug Assistance Program (ADAP) Supplemental Awards: HRSA-12-132 published August 20, 2011, and August 18, 2011, respectively. After a review of the language reflected in the two FOAs regarding the freezing of FY 2011 funds with the Division of Payment Management (DPM), HRSA has determined that the date be changed from September 1 to October 1 for this process. This is with the understanding that the final FFR submitted on or before July 30 be reconciled with the grantee Payment Management System account.

Due to the importance of the revised UOB reporting requirements, HAB will provide, in addition to this mailing, technical assistance to grantees regarding unobligated balances and carryover of grant funds.

If you have any questions regarding the content of this HAB Policy Notice, please contact your project officer. Thank you for your attention to this important matter.

Deborah Parham Hopson, PhD, RN, FAAN
Assistant Surgeon General
Associate Administrator

Attachments

#1 Part A Grantees
#2 Part B Grantees
#3 Examples
#4 Timelines

The purpose of all Ryan White HIV/AIDS Program funds is to ensure that eligible HIV-infected persons and families gain and/or maintain access to medical care. In accordance with the provisions of Title XXVI of the Public Health Service (PHS) Act, the following policy establishes guidelines for the unobligated balances (UOB) provisions affecting grantees under Parts A and B, including eligible metropolitan areas (EMAs), transitional grant areas (TGAs), States and United States Territories. It also explains the interaction between the UOB provisions and permissible carryover of grant funds.

Part A

Formula Funds

The Ryan White HIV/AIDS Program legislation requires that before the end of each grant year, a waiver to request carryover of unobligated formula funds is necessary regardless of the amount of remaining funds. A carryover waiver application, together with the estimated UOB, must be submitted to HRSA/HAB before the end of the grant year stating the purpose for which such funds will be expended during the carryover year. Once approved, carryover permits unobligated funds from one grant year to be added to funds in the following grant year.

Part A grantees must submit a waiver/carryover request NO LATER THAN DECEMBER 31 OF EACH YEAR (with an automatic extension to the first workday following December 31, should it be a weekend or holiday). Failure to submit a timely carryover request and estimated UOB to HRSA will result in a grantees being ineligible to receive Ryan White HIV/AIDS Program Part A formula carryover funds. If a grantees does not submit a carryover request by December 31 because there is no anticipated UOB, and then later identifies and reports Part A formula UOB on the final Federal Financial Report (FFR), the grantee is not eligible to submit a final Ryan White HIV/AIDS Program Part A carryover request, and no such request will be honored. If a waiver for carryover is approved, and, if at the end of the grant year, funds remain unobligated, the grantee can expend the approved UOB in accordance with the approved carryover waiver application.

The exact amount of unobligated funds must be reported on an FFR due annually on JULY 30 after the end of the grant year. NO EXTENSIONS WILL BE GRANTED FOR LATE SUBMISSION OF THE FINAL FFR. In addition, the grantee must submit a final carryover request with their final FFR or within 30 days of submitting the final FFR, containing the actual amount of UOB.

The timely submission of the final FFR is of critical importance to the successful administration of the Ryan White HIV/AIDS Program. Final FFRs are used by
HRSA/HAB to calculate statutory penalties; those penalties result in changes to the amounts of supplemental funds available for award in a subsequent fiscal year. Therefore, no final FFRs will be accepted after the due date of July 30, and grantees are put on notice that HRSA/HAB will utilize the grant balances available in the payment management system as of July 30 for the calculation of penalties. While UOB penalties are specific to UOB that exceeds five percent of the formula award, all grantees with UOB are subject to offset. An offset is a process in which reported unobligated funds that have not been approved for carryover are deobligated and utilized for future year supplemental awards, and the same amount of a grantee’s UOB is reduced from the future year award.

Note that the carryover formula funds will be used in the year prior to the offset, reduction, and ineligibility, as those penalties cannot be taken until after the final FFR is submitted. A timeline that demonstrates the interactions between the grant years is included as Attachment #4.

**For a complete flowchart detailing Part A Grantees and UOBs, see Attachment #1**

**UOB Penalties**

If unobligated balances of formula award exceed five percent, two penalties are imposed:

1. Future year award is reduced by amount of UOB less the amount of approved carryover; and

2. The grantee is not eligible for a future year supplemental award

NOTE that like all other grantees with UOB, the amount of UOB not covered by a waiver for carryover is subject to an offset, described above.

**If the grantee reports unobligated formula funds of five percent or less, no penalties are imposed, although a future year award will be subject to offset. Please see the examples in Attachment #3.**

**Supplemental Funds**

Under the Ryan White HIV/AIDS Program legislation, the Secretary has flexibility regarding supplemental funds. Grantees may not submit a carryover request for supplemental funds, which would permit those funds to be added to the subsequent grant year. Instead, UOB supplemental funds are subject to an offset. UOB supplemental funds do not make a grantee ineligible for a future year supplemental award.

Note that utilization of unused supplemental funds and the corresponding reduction will take place in the same grant year; as such actions are based on the final FFR due annually July 30 after the end of the grant year. **NO EXTENSIONS WILL BE GRANTED FOR LATE SUBMISSION OF THE FINAL FFR.**
Minority AIDS Initiative and Supplemental Funds

The unobligated balance provision does not apply to funds granted through the Minority AIDS Initiative (MAI) under section 2693 of the PHS Act. All grantees must track MAI funds separately and may request carryover of MAI funds to address the disproportionate impact of HIV/AIDS on racial and ethnic minorities.

Part B

The UOB Policy for Part B Formula, Supplemental and MAI funds is identical to the policy for Part A (see attachments), except that Part B grantees must submit a waiver and estimated carryover request **NO LATER THAN JANUARY 31 OF EACH YEAR.** Part B formula funds include the Part B Base and ADAP earmark formula awards; and supplemental funds include the ADAP Supplemental, Emerging Communities, and Part B Supplemental awards. In addition, the following policy applies:

Drug Rebates

The unobligated balance provision does not apply to funds from drug rebates under Part B. By law, drug rebate amounts are not considered part of the grant award and are not subject to the unobligated balances provisions. **Rebate funds should never be recorded as UOB on any FFR.** Rebates should be accounted for on the FFR not on line 10b. Instead, the total amount of rebates received during the reporting period should be identified under line 12 Remarks with attachment(s) as necessary. In accordance with 45 CFR section 92.21(f)(2), grantees must disburse rebates, and any earned interest on them, prior to requesting additional payments under their grant award. However, the Ryan White HIV/AIDS Program legislation has a specific exemption from the UOB penalties provision when grantees are unable to obligate grant funds because rebate funds must be obligated first. Grantees that would otherwise incur a penalty may request that the amount of the UOB equal to the amount of obligated rebate funds be carried forward to the next budget period without penalty. Such a request should accompany the final FFR and final carryover request due July 30, and no later than August 30. Any grantee that fails to request an adjustment based on rebate expenditures will be subject to the full UOB penalty.

**For a complete flowchart detailing Part B Grantees and UOBs, see Attachment #2**
Attachment #1

Does EMA/TGA have an unobligted balance?

NO
No Balance

YES
UOB Supplemental Award or Formula Award

Formula
Did EMA/TGA apply for waiver allowing for carryover of unobligated funds?

YES
If request for carryover is approved, UOB is available for expenditure for one year beginning upon the expiration date of the grant year. If funds are not expended in this time funds will be offset and made available for Supplemental Grants.

NO
If EMA/TGA does not request carryover, request is rejected, or approved request is less than the total UOB, the grantee may retain UOB for use in a later year, and offsets will be imposed. Offset funds will be made available for Supplemental Grants.

Is UOB Balance less than or equal to 5%  
(This provision applies regardless of receipt waiver)

UOB Balance less than or equal to 5%
No Penalty; UOB subject to offset

UOB Balance greater than 5%
The next FY following UOB, the grant will be reduced and offset by the UOB amount less approved carryover. And the grantee will not be eligible for a Supplemental award.
Attachment # 2

Part B Grantees

Does State have an unobligted balance?

NO
No Balance

YES
UOB Supplemental Award or Formula Award?

Formula
(Part B Base, ADAP earmark)
Did State apply for waiver allowing for carryover of unobligated funds?

YES
If request for carryover is approved, UOB is available for expenditure for one year beginning upon the expiration date of the grant year. If funds are not expended in this time funds will be offset and made available for Supplemental Grants.

NO
If State does not request carryover, request is rejected, or approved request is less than the total UOB, the grantee may retain UOB for use in a later year, and offsets will be imposed. Offset funds will be made available for Supplemental Grants.

Is UOB Balance less than or equal to 5%
(This provision applies regardless of receipt waiver)

UOB Balance less than or equal to 5%
No Penalty; UOB subject to offset

UOB Balance greater than 5%
The next FY following UOB, the grant will be reduced and offset by the UOB amount less approved carryover. And the grantee will not be eligible for a Supplemental award.

Supplemental
(ADAP supplemental, Supplemental, & Emerging Communities)
UOBs may be utilized in a future year but the same amount will be reduced from that grant. Reduced funds will be made available for Supplemental Grants.
Examples of how the UOB penalties and carryover will apply in specific instances (note that the examples are based on the Part A funding cycle):

Example 1:

- Grantee X is awarded $1.0 million for grant period March 1, 2010 – February 28, 2011.
- On or before December 31, 2010, Grantee requests a waiver and carryover of an estimated $50,000 (FY 2010 into FY 2011), which is approved. The $50,000 must be expended by February 28, 2012.
- Grantee submits a final FFR on July 30, 2011, that indicates a UOB for formula funds in the amount of $50,000, which is 5 percent of the grant.
- Penalties imposed:
  - None. The grantee is not subject to any penalties because the amount of formula UOB is 5 percent or less of the grant, regardless of request and approval for carryover.

Example 2:

- Grantee X is awarded $1.0 million for grant period March 1, 2010 – February 28, 2011.
- On or before December 31, 2010, Grantee requests a waiver and carryover of an estimated $80,000 (FY 2010 into FY 2011), which is approved. The $80,000 must be expended by February 28, 2012.
- Grantee submits a final FFR on July 30, 2011, that indicates a UOB for formula funds in the amount of $80,000, which is greater than 5 percent of the grant.
- Penalties imposed:
  - Future year award (March 1, 2012 – February 28, 2013) will be reduced by the amount of UOB less the amount of approved carryover: $0;
  - Future year (March 1, 2012 – February 28, 2013) ineligible for supplemental award
- In addition, future year award (March 1, 2012 – February 28, 2013) will be offset by the amount of the UOB less the amount of approved carryover: $0.

Example 3:

- Grantee X is awarded $1.0 million for grant period March 1, 2010 – February 28, 2011.
- On or before December 31, 2010, Grantee requests a waiver and carryover of an estimated $50,000 in unobligated funds (FY 2010 in to FY 2011), which is approved. The $50,000 must be expended by February 28, 2012.
- Grantee submits a final FFR on July 30, 2011 that indicates a UOB for formula funds in the amount of $80,000 which is greater than 5 percent of the grant. The amount approved for carryover remains $50,000.
• Penalties imposed:
  o Future year award (March 1, 2012 – February 28, 2013) is offset by the amount of UOB less the amount of approved carryover: $30,000;
  o Future year award (March 1, 2012 – February 28, 2013) is reduced by the amount of UOB less the amount of approved carryover: $30,000;
  o Future year (March 1, 2012 – February 28, 2013) ineligible for supplemental award.
  o Because some of the UOB was not approved for carryover, expenditure of that portion is the same as with supplemental funds: the grantee may use the funds in a future year (March 1, 2012 – February 28, 2013), but the funds must be offset by the same amount, and the offset will be added to that same year’s supplemental pool of funds.

Example 4:

• Grantee X is awarded $1.0 million for grant period March 1, 2010 – February 28, 2011.
• Grantee does not anticipate a need for carryover, and does not submit any waiver or estimated carryover request as of December 31, 2010.
• Grantee submits a final FFR on July 30, 2011 that indicates a UOB for formula funds in the amount of $50,000, which is 5 percent of the grant.
• Penalties imposed:
  o None. The grantee is not subject to any penalties because the amount of formula UOB is 5 percent or less of the grant, regardless of request and approval for carryover.
  o Because the UOB was not approved for carryover, expenditure is the same as with supplemental funds: the grantee may use the funds in a future year (March 1, 2012 – February 28, 2013), but the funds must be offset by the same amount, and the offset will be added to that same year’s supplemental pool of funds.

Supplemental Funds

• Grantee X is awarded $1.0 million for grant period March 1, 2010 – February 28, 2011.
• Grantee reports UOB supplemental funds on a final FFR submitted July 30, 2011; the grantee may retain those funds for use in the next following grant year, March 1, 2012 – February 28, 2013.
• That same future grant year’s supplemental award (March 1, 2012 – February 28, 2013) will be reduced by the amount of the UOB supplemental funds.
Attachment #4

Timelines

Part A:

• March 1: Grant year 1 begins.
• December 31: Grantee submits grant year 1 waiver request and estimated carryover request, including intended use of funds. IF NOT SUBMITTED, NO CARRYOVER WILL BE PERMITTED.
• February 28: Grant year 1 ends.
  o March 1: Grant year 2 begins.
• July 30: Grantee submits grant year 1 final FFR and final carryover request. NO EXTENSIONS.
• October 1: HRSA/HAB finalizes grant year 1 carryover requests, both approvals and denials, and calculates penalties.
  o December 31: Grantee submits grant year 2 waiver request and estimated carryover request, including intended use of funds. IF NOT SUBMITTED, NO CARRYOVER WILL BE PERMITTED.
  o February 28: Grant year 2 ends.
    ▪ March 1: Grant year 3 begins; funds available for supplemental awards include penalties calculated from grant year 1.
  o July 30: Grantee submits grant year 2 final FFR and final carryover request. NO EXTENSIONS.
  o October 1: HRSA/HAB finalizes grant year 2 carryover requests, both approvals and denials, and calculates penalties.
    ▪ December 31: Grantee submits grant year 3 waiver request and estimated carryover request, including intended use of funds. IF NOT SUBMITTED, NO CARRYOVER WILL BE PERMITTED.
    ▪ February 28: Grant year 3 ends.
      ▪ March 1: Grant year 4 begins; funds available for supplemental awards include penalties calculated from grant year 2.

Part B:

• April 1: Grant year 1 begins.
• January 31: Grantee submits grant year 1 waiver request and estimated carryover request, including intended use of funds. IF NOT SUBMITTED, NO CARRYOVER WILL BE PERMITTED.
• March 31: Grant year 1 ends.
  o April 1: Grant year 2 begins.
• July 30: Grantee submits grant year 1 final FFR and final carryover request. NO EXTENSIONS.
• October 1: HRSA/HAB finalizes grant year 1 carryover requests, both approvals and denials, and calculates penalties.
  o January 31: Grantee submits grant year 2 waiver request and estimated carryover request, including intended use of funds. IF NOT SUBMITTED, NO CARRYOVER WILL BE PERMITTED.
  o March 31: Grant year 2 ends.
    ▪ April 1: Grant year 3 begins; funds available for supplemental awards include penalties calculated from grant year 1.
  o July 30: Grantee submits grant year 2 final FFR and final carryover request. NO EXTENSIONS.
  o October 1: HRSA/HAB finalizes grant year 2 carryover requests, both approvals and denials, and calculates penalties.
    ▪ January 31: Grantee submits grant year 3 waiver request and estimated carryover request, including intended use of funds. IF NOT SUBMITTED, NO CARRYOVER WILL BE PERMITTED.
    ▪ March 31: Grant year 3 ends.
      ▪ April 1: Grant year 4 begins; funds available for supplemental awards include penalties calculated from grant year 2.
Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services

History: This policy was previously published as Policy Notice 02-01 and Policy Notice 07-06.

This updated policy reflects the changes in Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program) and establishes updated guidelines for the use of Ryan White HIV/AIDS Program funds for allowable expenditures for outreach services for all of the Parts, except for the Special Projects of National Significance Program.

This policy also clarifies the updated guidelines for allowable expenditures for outreach services in the context of the National HIV/AIDS Strategy (NHAS). The NHAS has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people with HIV, and 3) reducing HIV-related health disparities.

In applying for Ryan White HIV/AIDS Program Part A and B funding, applicants must include a description of the strategy, plan, and data associated with the early identification of individuals who are unaware of their HIV/AIDS status. Early Identification of Individuals with HIV/AIDS (EIIHA) is the identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care. The goals of this initiative are to increase: 1) the number of individuals who are aware of their HIV status, 2) the number of HIV positive individuals who are in medical care, and 3) the number of HIV negative individuals referred to services that contribute to keeping them HIV negative. When funding outreach in support of the EIIHA initiative, grantees must structure outreach activities targeting specific at risk populations in accordance with their EIIHA strategy and plan.

The purpose of all Ryan White HIV/AIDS Program funds is to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured and therefore unable to pay for HIV/AIDS health care and vital health-related supportive services. Outreach services are designed to identify persons at high risk for HIV and provide an array of early intervention and prevention services. Outreach services include services to both HIV-infected persons who know their status and are not in care and HIV-infected persons who are unaware of their status and are not in care.

Outreach services are considered to be support services under the Ryan White HIV/AIDS Program legislation. As such, in the absence of a core medical services waiver, Parts A, B and C grantees are required to limit their expenditures for all support services to 25 percent of available service dollars. Conversely, these grantees are required to expend 75 percent of their service dollars on core medical services, placing the emphasis of Ryan White HIV/AIDS Program funding on life-saving and life-extending services.
Outreach Service Guidance for Grantees

All Ryan White HIV/AIDS Program Grantees may continue to use funds to pay for HIV counseling and testing, outreach, and referral services, as provided in the Ryan White HIV/AIDS Program legislation however, Parts A, B and C Grantees are limited to the percentage of grant funds that may be expended for outreach and other support services. As such, these Grantees are expected to prioritize the support services most appropriate for their geographical area and client needs and fund those services first. Grantees may continue to target and identify individuals who may or may not know their HIV status and are not in care, have not returned for treatment services or do not adhere with treatment requirements, if they determine that these services are needed for the populations they serve.

The Use of Ryan White HIV/AIDS Program Funds for Outreach Services

Federal funds received under the Ryan White HIV/AIDS Program may continue to be used for outreach activities which have as their principal purpose targeting activities, under specific needs assessment-based service categories, that can identify individuals with HIV disease. This includes those who know their HIV status and are not in care as well as those individuals who are unaware of their HIV status, so that they become aware of the availability of HIV-related services and enroll in primary care, AIDS Drug Assistance Programs, and support services that enable them to remain in care.

1. Goal of Outreach Services

The goal of outreach services continues to be to link individuals into care that would ultimately result in ongoing primary care and increased adherence to medication regimens. Outcome measures need to be defined by grantees that reflect the goal to evaluate the success of outreach activities. Broad activities such as providing "leaflets at a subway stop" or "a poster at a bus shelter" would not meet the intent of the law. This policy continues to give grantees flexibility to target and identify individuals who may or may not know their HIV status and are not in care, have not returned for treatment services or do not adhere with treatment requirements; however, HAB encourages grantees to coordinate outreach activities with Center for Disease Control and Prevention (CDC)-funded and State-funded providers where there is a greater emphasis on outreach and case finding than the Health Resources and Services Administration-funded programs.

2. Appropriate Support Services

An outreach component is not a requirement for Ryan White HIV/AIDS Program-funded grantees. Each individual Ryan White HIV/AIDS Program grantee under Parts A, B, C, D and F (except SPNS programs) should determine if outreach services are an appropriate support service for funding in their service area. As noted above, Parts A, B, and C grantees of the Ryan White HIV/AIDS Program must expend 75 percent of available service dollars on core medical services for their clients. Support services may be funded out of the remaining 25 percent of grant funds and may include in addition to outreach services, such services as: respite care for persons caring for individuals with HIV/AIDS, medical transportation, linguistic services, and referrals for
health care and support services. This is not an all inclusive list of support services and grantees must determine which of the support services they will implement based on services that are needed for individuals with HIV/AIDS to achieve their medical outcomes.

3. Outreach activities supported with Ryan White HIV/AIDS Program funds must continue to be:

a. Planned and delivered in coordination with State and local HIV prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes;

b. Directed to populations known, through local epidemiological data or through review of service data or through a strategic planning process, to be at disproportionate risk for HIV infection; the National HIV/AIDS Strategy identifies the following disproportionate at risk populations: Gay and Bisexual Men, Transgender Individuals, Black Americans, Latino Americans, Substance Abusers, Asian Americans, Pacific Islander and American Indian, and Alaska Natives;

c. Conducted in such a manner, (i.e., time of day, month, events, sites, method, culturally/linguistically appropriate) among those known to have delayed seeking care relative to other populations, etc., and continually reviewed and evaluated in order to maximize the probability of reaching individuals infected with HIV who are unaware of their serostatus or know their status but are not actively in treatment;

d. Designed to:

1. Establish and maintain an association with entities that have effective contact with persons found to be disproportionately impacted by HIV or disproportionately differ in local access to care, e.g., prisons, homeless shelters, substance abuse treatment centers, etc.

2. Direct individuals to early intervention services (EIS) or primary care (HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services with appropriate providers of health and support services).

3. Include appropriately trained and experienced workers to deliver the access to care message when applicable.

4. Provide quantifiable outcome measures (tracking and data collection) such as the number of individuals reached of previously unknown HIV status who now know they are positive, and/or the number of HIV positive individuals not in care who are now in care;

e. Determined to be a priority service by Part A planning bodies, Part B grantees and State planning bodies, and be necessary to implement the EMA, TGA, or State wide comprehensive plan and associated strategies.
4. Points of Entry

If and when Part A, Part B, and Part C Grantees determine that outreach services are appropriate and should be funded with allotted support service funds, then coordination with early intervention services and other points of entry into care is still applicable.

Ryan White HIV/AIDS Program Parts A and B grantees are still allowed to fund outreach services to link persons with HIV disease into care. Current legislation includes language under Early Intervention Services (EIS) which identifies the entities through which individuals may access HIV-related health services such as, public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and other points of access to care identified through referral mechanisms. Grantees should coordinate outreach services such that they include these and all other key points of entry as sites where targeted outreach activities are coordinated and conducted.

5. Early Intervention Services (EIS):

The grantee can use outreach to identify and refer individuals to new and existing early intervention services. Early intervention services stress the importance of bringing persons into care earlier in HIV disease progression. Outreach services are aimed at identifying persons with HIV who may know or be unaware of their status and are not in care. Early intervention services, i.e. providing HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services and linkages to care with appropriate providers of health and support services are eligible services for all Parts under the Ryan White HIV/AIDS Program.

6. Prohibited Use of Funds

a. Funds awarded under the Ryan White HIV/AIDS Program may not be used for outreach activities that exclusively promote HIV prevention education. Broad scope awareness activities that address the general public (poster campaigns for display on public transit, billboards, TV or radio announcements, etc.) may be funded provided that they are targeted and contain HIV information with explicit and clear links to health care services and assist to optimize health outcomes.

b. Outreach activities should supplement, and not supplant, such activities that are carried out with amounts appropriated under Section 317 of the Public Health Service Act, "Project Grants for Preventive Health Services" administered by the CDC or with other Federal, State or local funds.
7. **Payer of Last Resort**

The grantee must ensure that Ryan White HIV/AIDS Program funds, including those funds used for outreach services remain the payer of last resort.

If you have any questions regarding the content of this HAB Policy Notice, please contact your project officer.
Policy Notice-11-04: Use of Ryan White HIV/AIDS Program Funding for Staff Training

History: Issued on February 1, 1998 as Policy No. 98-02; reissued June 1, 2000.

Parts A, B, C and D Grantee Administration and/or Clinical Quality Management funds may be used to support specific HIV staff training that is designed to enhance an individual's or an organization's ability to improve the quality of services provided to eligible clients, so long as such costs do not exceed the legislatively mandated caps on Grantee Administration and Clinical Quality Management.

Similarly, Parts A, B, C and D funded providers may utilize administrative funds and/or service-specific capacity development funds to support HIV staff training.

- Administrative funds used for this purpose are subject to the legislatively mandated aggregate provider administration cap.
- Service-specific capacity development dollars utilized for this purpose should be carefully monitored by the Ryan White HIV/AIDS Program Grantee, and should not exceed 5 percent of the dollars contracted to provide the service.

Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay for professional licensure.
Centers for Disease Control and Prevention (CDC), announces the establishment of the World Trade Center (WTC) Health Program Scientific/Technical Advisory Committee.

The WTC Health Program shall provide, beginning on July 1, 2011: (1) Medical monitoring and treatment benefits to eligible emergency responders and recovery and cleanup workers (including those who are Federal employees) who responded to the September 11, 2001, terrorist attacks; and (2) initial health evaluation, monitoring, and treatment benefits to residents and other building occupants and area workers in New York City, who were directly impacted and adversely affected by such attacks. This advisory committee will review scientific and medical evidence and make recommendations to the WTC Program Administrator on additional WTC Health Program eligibility criteria and additional WTC-related health conditions. The committee may be consulted on other matters as related to and outlined in the Act at the discretion of the WTC Program Administrator.

For information, contact Larry Elliott, Designated Federal Officer. World Trade Center Health Program Scientific/Technical Advisory Committee, National Institute for Occupational Safety and Health, HHS, CINC Building, ROBER Room 141, M/S C46, Cincinnati, Ohio 45226, telephone (513) 533–6891, or fax (513) 533–6826.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities for both the Centers for Disease Control and Prevention, and the Agency for Toxic Substances and Disease Registry.

Dated: May 5, 2011.

Elaine L. Baker,
Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2011–11683 Filed 5–11–11; 8:45 am]
BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Interest Projects (SIPs): Initial Review

The meeting announced below concerns “Using Behavioral Economics to Promote Colorectal Cancer Screening in Disadvantaged Communities. SIP11–041, Feasibility Study to Link Data from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), the National Program of Cancer Registries (NPCR), and Medicare to Evaluate Screening Practice and Treatment Outcomes of Former NBCCEDP Clients, SIP11–043, Potential for Cancer Screening Interventions for Cancer Survivors Delivered Through Central Cancer Registries, SIP11–044, Panel B,” initial review.

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

Times And Dates: 8:30 a.m.–5:30 p.m., June 1, 2011 (Closed). 8:30 a.m.–5:30 p.m., June 2, 2011 (Closed).

Place: Georgian Terrace Hotel, 659 Peachtree Street, NE., Atlanta, Georgia 30308, Telephone: (404) 989–8303.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c) (4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters To Be Discussed: The meeting will include the initial review, discussion, and evaluation of “Using Behavioral Economics to Promote Colorectal Cancer Screening in Disadvantaged Communities, SIP11–041, Feasibility Study to Link Data from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), the National Program of Cancer Registries (NPCR), and Medicare to Evaluate Screening Practice and Treatment Outcomes of Former NBCCEDP Clients, SIP11–043, Potential for Cancer Screening Interventions for Cancer Survivors Delivered Through Central Cancer Registries, SIP11–044, Panel B,” initial review.

Contact Person For More Information: Brenda Colley Gilbert, PhD, M.P.H., Director, Extramural Research Program Office, National Center for Chronic Disease Prevention and Health Promotion, CDC, 4770 Buford Highway, NE., Mailstop K–92, Telephone: (770) 488–6295, BJCa@cdc.gov.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

HIV/AIDS Bureau Policy Notice 11–01 (Replaces Policy Notice 99–02)

AGENCY: Health Resources and Services Administration (HRSA), HHS.

ACTION: Final Notice.

SUMMARY: The Health Resources and Services Administration, HIV/AIDS Bureau (HAB) Policy Notice 99–02 established policies for the use of Ryan White HIV/AIDS Program funds authorized under Title XXVI of the Public Health Service (PHS) Act, for housing referral services and short-term or emergency housing needs. Amendment #1 to Policy Notice 99–02, effective March 27, 2008, modified Policy Notice 99–02 by imposing a 24-month cumulative cap on short-term and emergency housing assistance. The limit on benefits would have taken effect on March 27, 2010, and would have impacted individuals who were users of the funds for housing assistance. HRSA received comments from the public concerning the potential impact of the cap and the threat to the ability of clients receiving Ryan White HIV/AIDS Program funds to receive housing services. In response, HRSA’s Administrator directed that Policy Notice 99–02 Amendment #1 be rescinded, as published in the February 10, 2010, Federal Register notice Volume 75, Issue 27, pages 6672–6673. In addition, the notice indicated that HRSA was conducting a comprehensive review of the Housing Policy. As a result of a thorough vetting and comprehensive review, HRSA is issuing a final notice of Housing Policy Notice 11–01 which replaces HAB Policy Notice 99–02, effective May 12, 2011.

SUPPLEMENTARY INFORMATION: On February 10, 2010, HRSA rescinded Amendment #1 to Policy Notice 99–02 effective immediately, as published in the Federal Register. Grantees were advised that HRSA did not require enforcement of the cap for beneficiaries that might have been at or near the 24-month limit on receipt of funds used for short-term and emergency housing.
assistance. HRSA announced that a comprehensive review of the Housing Policy would continue and HRSA’s Administrator would continue to consider all aspects of the policy.

**Comprehensive Review of the Housing Policy**

HRSA received numerous letters from consumer and housing advocates expressing their concerns regarding the potential effect on individuals reaching the 24-month cap to receive funding used for housing services. HRSA’s Administrator responded to these concerns by conducting face-to-face meetings with housing advocates, consumers, and HIV/AIDS stakeholders/organizations. In addition, Ryan White HIV/AIDS Program Grantees were asked to submit their views on the Housing Policy’s lifetime 24-month cap per household. Consequently, HAB collaborated with other federal agencies and discussed mutual concerns with the Assistant Secretary of the U.S. Department of Housing and Urban Development and the Director of Housing Opportunities for Persons with AIDS.

**HRSA/HAB Policy Considerations and Recommendations**

HAB’s Associate Administrator solicited comments from all Part A, B and D Grantees asking them to review five principles that were under consideration for the revised Housing Policy and to provide comments, concerns, and additional considerations by May 21, 2010. The five principles were as follows:
1. Strengthen linkages to the U.S. Department of Housing and Urban Development’s (HUD) programs, as well as state and local housing resources to provide longer-term assistance;
2. Minimize housing disruptions for people living with HIV/AIDS;
3. Integrate housing with a broader range of supports that collectively support individuals in maintaining their health;
4. Provide flexibility to respond to exceptional circumstances; and
5. Minimize the burden on Ryan White providers who are responsible for assisting HAB to implement any housing policy.

There were four responses—two from Ryan White HIV/AIDS Program Part A Grantees, one from a Part B Grantee and one letter from the National AIDS Housing Coalition’s Executive Director. These responses supported the extension of funding for housing services beyond the 24-month cap due to exceptions, i.e., “Grantees allowing transitional housing of greater than 24 month in duration must review their decision periodically to assess whether this standard serves as a significant barrier to access to housing services for new clients.” “It is recognized that a transitional housing limit of 24 month may be a significant barrier for certain populations, for example a multiply-diagnosed client who has been in housing before, but has lapsed and needs housing support while in treatment and recovery.”

Other considerations included:
1. HRSA/HAB consideration to promote decision making at the jurisdictional level based on needs assessment, consistent with the Ryan White HIV/AIDS Program legislative mandates, and
2. Acknowledging the changes in the 2006 Ryan White HIV/AIDS Program reauthorization that limited funding for support services to 25 percent of available service dollars. As a result of this comprehensive review, HAB recommended issuance of a revised Housing Policy.

**HRSA HAB Policy Notice 11–01 (Replaces 99–02)**

**Document Title:** The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs

The following policy establishes guidelines for allowable housing-related expenditures under the Ryan White HIV/AIDS Program. The purpose of all Ryan White HIV/AIDS Program funds is to ensure that eligible HIV-infected persons and families gain or maintain access to medical care.

A. Funds received under the Ryan White HIV/AIDS Program (Title XXVI of the Public Health Service Act) may be used for the following housing expenditures:
   i. Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed; or
   ii. Short-term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either:
      a. Housing services that include some type of medical or supportive service: including, but not limited to, residential substance treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or
      b. Housing services that do not provide direct medical or supportive services, but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment; necessity of housing services for purposes of medical care must be certified or documented.

B. Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation.

C. Housing funds cannot be in the form of direct cash payments to recipients or services and cannot be used for mortgage payments.

D. The Ryan White HIV/AIDS Program must be the payer of last resort. In addition, funds received under the Ryan White HIV/AIDS Program must be used to supplement, but not supplant funds currently being used from local, state, and federal agency programs.

Ryan White HIV/AIDS Program Grantees must be capable of providing HAB with documentation related to the use of funds as the payer of last resort and the coordination of such funds with other local, state, and federal funds.

E. Ryan White HIV/AIDS Program Grantees and local decision making planning bodies, i.e. Part A and Part B, are strongly encouraged to institute duration limits to provide transitional and emergency housing services. HUD defines transitional housing as 24 month, and HAB/HAB recommends that grantees consider using HUD’s definition as their standard.

F. Grantees must develop mechanisms to allow newly identified clients access to housing services.

G. Upon request, Ryan White HIV/AIDS Program Grantees must provide HAB with an individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services.

H. Housing-related expenses are limited to Part A, Part B, and Part D of the Ryan White HIV/AIDS Program and are not allowable expenses under Part C. Part A and Part B Grantees must adhere to the Core Medical Services requirement; only 25 percent of Ryan White HIV/AIDS Program funding may be used for support services without a waiver.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Advisory Commission on Childhood Vaccines; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given of the following meeting:

**Name:** Advisory Commission on Childhood Vaccines (ACCV).

**Date and Time:** June 9, 2011, 1 p.m. to 5 p.m. EDT; June 10, 2011, 9 a.m. to 12 p.m. EDT.

**Place:** Parklawn Building (and via audio conference call), Conference Rooms G & H, 5600 Fishers Lane, Rockville, MD 20857.

The ACCV will meet on Thursday, June 9 from 1 p.m. to 5 p.m. (EDT) and on Friday, June 10 from 9 a.m. to 12 p.m. (EDT). The public can join the meeting via audio conference call by dialing 1–800–369–3104 from 1 p.m. to 5 p.m. (EDT) and on Friday, June 10 from 9 a.m. to 12 p.m. (EDT). The public can join the meeting via audio conference call by dialing 1–800–369–3104 on June 9 and 10 and providing the following information:

**Leader's Name:** Dr. Geoffrey Evans.

**Password:** ACCV.

**Agenda:** The agenda items for the June meeting will include, but are not limited to: updates from the Division of Vaccine Injury Compensation (DVIC), Department of Justice (DOJ), National Vaccine Program Office, Immunization Safety Office (Centers for Disease Control and Prevention), National Institute of Allergy and Infectious Diseases (National Institutes of Health), and Center for Biologics, Evaluation and Research (Food and Drug Administration). A draft agenda and additional meeting materials will be posted on the ACCV Web site (http://www.hrsa.gov/vaccinecompensation/accv.htm) prior to the meeting. Agenda items are subject to change as priorities dictate.

**Public Comment:** Persons interested in attending the meeting in person or providing an oral presentation should submit a written request, along with a copy of their presentation to: Annie Herzog, DVIC, Healthcare Systems Bureau (HSB), Health Resources and Services Administration (HRSA), Room 11C–26, 5600 Fishers Lane, Rockville, Maryland 20857 or e-mail: aherzog@hrsa.gov. Requests should contain the name, address, telephone number, e-mail address, and any business or professional affiliation of the person desiring to make an oral presentation. Groups having similar interests are requested to combine their comments and present them through a single representative. The allocation of time may be adjusted to accommodate the level of expressed interest. DVIC will notify each presenter by e-mail, mail or telephone of their assigned presentation time. Persons who do not file an advance request for a presentation, but desire to make an oral statement, may announce it at the time of the public comment period. Public participation and ability to comment will be limited to space and time as it permits.

**For Further Information Contact:** Anyone requiring information regarding the ACCV should contact Annie Herzog, DVIC, HSB, HRSA, Room 11C–26, 5600 Fishers Lane, Rockville, MD 20857; telephone (301) 443–6593 or e-mail: aherzog@hrsa.gov.

Dated: May 6, 2011.

Reva Harris, Acting Director, Division of Policy and Information Coordination.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health

National Center for Complementary & Alternative Medicine; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

**Name of Committee:** National Center for Complementary and Alternative Medicine Special Emphasis Panel; IEARDA.

**Date:** June 6–7, 2011.

**Time:** 8 a.m. to 5 p.m.

**Agenda:** To review and evaluate grant applications.

**Place:** Doubletree Hotel Bethesda, (Formerly Holiday Inn Select), 8120 Wisconsin Avenue, Bethesda, MD 20814.

**Contact Person:** Michele C. Hindi-Alexander, PhD, Scientific Review Officer, Division of Scientific Review, Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, 6100 Executive Blvd., Room 5B01, Bethesda, MD 20892, 301–435–8382, hindialem@mail.nih.gov.

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: May 6, 2011.

Jennifer S. Spaeth, Director, Office of Federal Advisory Committee Policy.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health

Eunice Kennedy Shriver National Institute of Child Health & Human Development; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

**Name of Committee:** National Institute of Child Health and Human Development Special Emphasis Panel; IEARDA.

**Date:** June 6–7, 2011.

**Time:** 8 a.m. to 5 p.m.

**Agenda:** To review and evaluate grant applications.

**Place:** Doubletree Hotel Bethesda, (Formerly Holiday Inn Select), 8120 Wisconsin Avenue, Bethesda, MD 20814.

**Contact Person:** Michele C. Hindi-Alexander, PhD, Scientific Review Officer, Division of Scientific Review, Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, 6100 Executive Blvd., Room 5B01, Bethesda, MD 20892, 301–435–8382, hindialem@mail.nih.gov.

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: May 6, 2011.

Jennifer S. Spaeth, Director, Office of Federal Advisory Committee Policy.

Federal Register / Vol. 76, No. 92 / Thursday, May 12, 2011 / Notices 27651

Dated: May 6, 2011.

Jennifer S. Spaeth, Director, Office of Federal Advisory Committee Policy.

BILLING CODE 4140–01–P
Law & Policy: Policy Notice - 07-05

Document Title: The Use of the Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance

DATE: SEP 19 2007

TO: All Ryan White HIV/AIDS Program Grantees

Attached is the HIV/AIDS Bureau (HAB) updated policy describing the use of Ryan White HIV/AIDS Program Part B AIDS Drug Assistance Program (ADAP) funds to purchase health insurance. This policy was previously published as “Policy Notice 99-01.” This updated policy reflects the technical changes in Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) and establishes updated guidelines for the use of Ryan White HIV/AIDS Program Part B ADAP funds for the purchase of health insurance. In essence, the previous policy has not undergone any substantive changes and is being re-issued to reflect the technical changes as a result of the newly reauthorized Ryan White HIV/AIDS Program.

Funds designated to carry out the provisions of Section 2616 of the Public Health Service Act may be used to purchase health insurance whose coverage includes HIV treatments and access to comprehensive primary care services, subject to specific conditions.

If you have any questions regarding the content of the HAB Policy Notice, please contact your project officer. Thank you for your attention to this important matter.

Deborah Parham Hopson, Ph.D., R.N.
Assistant Surgeon General
Associate Administrator

Attachment
Policy Notice 07-05: The Use of Ryan White HIV/AIDS Program Part B AIDS Drug Assistance Program (ADAP) Funds to Purchase Health Insurance

The following HIV/AIDS Bureau (HAB) policy is being issued to support individual States in the management of their HIV/AIDS programs and to ensure that ADAPs are the payers of last resort.

A. Funds designated to carry out the provisions of Section 2616 of the Public Health Service Act may be used to purchase health insurance whose coverage includes the full range of HIV treatments and access to comprehensive primary care services, subject to the conditions below:

1. Funds must continue to be managed as part of the established ADAP Program.

2. ADAP programs must be able to account for and report on funds used to purchase and maintain insurance policies for eligible clients including covering any costs associated with these policies.

3. Funds may only be used to purchase premiums from health insurance plans that at a minimum provide prescription coverage equivalent to the Ryan White HIV/AIDS Program Part B formulary.

4. The total annual amount spent on insurance premiums can not be greater than the annual cost of maintaining that same population on the existing ADAP program.

5. Funds may be used to cover any costs associated with the health insurance policy, including copayments, deductibles, or premiums to purchase or maintain insurance policies.

6. Current client eligibility guidelines, set under Section 2616(b) of the Public Health Service Act, must be followed.

7. The States must maintain their contributions to their HIV/AIDS care programs as required under Section 2617(b)(7)(E).
8. Ryan White HIV/AIDS Program funds must be the payers of last resort for pharmaceuticals.

9. The State must assure that ADAP funds will not be used to purchase health insurance deemed inadequate by the State in its provision of comprehensive primary care services.

B. Prior to the use of ADAP funds for the purchase of health insurance, States must provide the HIV/AIDS Bureau with the methodology used by the State to:

1. Assure that they are buying health insurance that at a minimum includes pharmaceutical benefits equivalent to the Ryan White HIV/AIDS Program Part B ADAP formulary (refer to A.3.), and

2. Assess and compare the costs of providing medications through the health insurance option versus the existing ADAP program (refer to A.4.).

3. If the use of ADAP funds for buying insurance is initiated within a grant cycle, the State ADAP will provide notification of intent with the aforementioned assurances to the Grants Management Officer.

C. Nothing in the above policy may be interpreted or construed to change existing requirements, authorized by law or policy guidelines, regarding, but not limited to: client eligibility, statewide parity for client eligibility, and statewide parity for treatments available in the ADAP formulary.
DATE: September 28, 2007

TO: All Ryan White HIV/AIDS Program Grantees

Attached is the HIV/AIDS Bureau (HAB) updated policy describing the use of Ryan White HIV/AIDS Program funds for transitional social support and primary care services for incarcerated persons. This policy was previously published as "Policy Notice 01-01." This updated policy reflects the changes in Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) and establishes updated guidelines for the use of Ryan White HIV/AIDS Program funds for transitional social support and primary care services for incarcerated persons for Parts A through D of the Ryan White HIV/AIDS Program.

The attached policy supports the use of Ryan White HIV/AIDS Program funds for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning or when they are in the correctional system for a brief period, which would not include any discharge planning.

If you have any questions regarding the content of the HAB Policy Notice, please contact your project officer. Thank you for your attention to this important matter.

Deborah Parham Hopson, Ph.D., R.N.
Assistant Surgeon General
Associate Administrator

Overview

The following policy establishes guidelines for allowable expenditures under the Ryan White HIV/AIDS Program for incarcerated persons when they: (a) prepare to exit the correctional system as part of effective discharge planning; or (b) are in the correctional system for a brief period, which would not include any type of discharge planning. 'Incarcerated person' refers to an individual involuntarily confined in association with an allegation or finding of behavior that is subject to criminal prosecution. Thus, the policy applies to individuals who are involuntarily living in the secure custody of law enforcement, judicial, or penal authorities. Furthermore, this includes individuals who reside in a community setting (which is not part of the institutional setting of the prison system such as a pre-release residential half-way house) if the individual is still involuntarily confined to those settings.
The intent of all Ryan White HIV/AIDS Program funds is to ensure that eligible HIV-infected persons gain or maintain access to HIV-related care and treatment. This policy recognizes that many incarcerated persons will ultimately be the responsibility of the Ryan White HIV/AIDS Program, so early detection, entry into care, and access to and continuity of care are important reasons to use Ryan White HIV/AIDS Program funds for incarcerated persons who meet the qualifications specified above.

The purpose of this policy is to provide grantees flexibility in providing necessary, and otherwise unavailable, transitional primary care and social support services to incarcerated persons in the custody of a local, State, or Federal correctional system who are either nearing release or whose incarceration is of short duration. Grantees who want to develop these linkages should become familiar with local prisons or jails and the State and Federal correctional facilities as well as the procedures established to prepare inmates for release into the community. These systems could vary greatly across localities and regions. Grantees should work with the appropriate corrections administrators to determine what health services are legally expected to be provided within the correctional system and how, and whether, the correctional system addresses the discharge planning needs, continuity of treatment, and community linkages for inmates infected with HIV/AIDS.

We envision grantees who establish transitional social services will link the inmate to HIV/AIDS care and treatment and transitional primary care services. These services could be provided in the correctional facility prior to release as part of discharge planning. In the case of a short term facility, like a local jail, which does not provide discharge planning, services would be outside of the facility. In either situation, these services are not covered by the correctional system. Transitional primary care services can also be provided on a short term basis in an outpatient setting. Working with the correctional system, grantees must determine 1) What the release date of the inmate is; 2) what health care services are provided by the correctional system; and 3) what services the Ryan White HIV/AIDS Program funds can provide.

There is an important statutory point of reference that defines under what circumstances the Ryan White HIV/AIDS Program-funds can be used by grantees to provide services for incarcerated persons. Specifically, the payer of last resort statutory provision found in Sections 2605(a)(6), 2617(b)(7)(F), and 2664(f) of Title XXVI of the Public Health Service Act requires that funds received under a Ryan White grant award not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made. With respect to such item or service covered under other programs, these include those covered under any State's compensation program, an insurance policy, or under Federal and State health benefit program (except for a program administered by or providing the services of the Indian Health Service). In 1996, the Office of the Inspector General's (OIG) audit of a
State's Ryan White HIV/AIDS Part B Program, found Ryan White HIV/AIDS Program funds were used to provide transitional services to inmates within 90 days of release, even though under that State's law inmates 'have a right to medical care and prison officials have a corresponding duty to provide such care.' The OIG did not disagree with the use of Ryan White HIV/AIDS Program funds to support transitional services for inmates, but rather in this audit, said that the State used Ryan White HIV/AIDS Program funds to support such services when the State was already paying for transitional services for other inmates. Under the context described above, the policy provides for the use of funds for transitional social services (e.g., medical case management and social support services) to help achieve immediate linkages to community-based care and treatment services upon release from custody, where no other services exist, or where these services are NOT the responsibility of the correctional system. The policy also provides for the use of funds for transitional primary care services prior to release or during a period of short-term incarceration where no other services exist, or where these services are NOT the responsibility of the correctional system.

**Policy Notice 07-04: The Use of Ryan White HIV/AIDS Program Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons**

Federal funds received under the Ryan White HIV/AIDS Program, as established in Title XXVI of the Public Health Service Act, may be used for short-term, transitional social support, and primary care services for an incarcerated person as they prepare to exit the correctional system as part of effective discharge planning (or who are incarcerated for a brief period with no formal discharge planning) and are otherwise eligible for Ryan White HIV/AIDS Program services under the following conditions:

**I. Incarcerated Person**

'Incarcerated person' refers to an individual involuntarily confined in association with an allegation or finding of behavior that is subject to criminal prosecution. Thus, the policy applies to individuals who are involuntarily living in the secure custody of law enforcement, judicial, or penal authorities. Furthermore, this includes individuals who reside in a community setting (which is not part of the institutional setting of the prison system such as a pre-release residential half-way house) if the individual is still involuntarily confined to those settings.

**II. Transitional Social Services**

A. Funded transitional social support services are those services that are needed by incarcerated persons with HIV/AIDS to establish or re-establish linkages to HIV/AIDS care and treatment services in community-based systems of care in order to achieve their medical outcomes during the time period as indicated in this policy. A service, such as case
management, that links the individual with established primary care is an example of an appropriate transitional social service

B. Recognizing that the determination of non-covered services is unique to each local, State, and Federal facility, and the grantee is responsible for assessing the extent to which such services are or should be covered by the correctional institution, the grantee must delineate precisely what services will be provided by the grantee and ensure that they are not available from the correctional system.

C. The grantee must ensure that these support services are funded only from the portion of the grant remaining after reserving amounts for purposes of providing core medical services, quality management and covering administrative expenses specified in statute under Parts A, B, and C of the Ryan White HIV/AIDS Program. In addition, the grantee must ensure that such services supplement, but do not supplant, existing programs or responsibilities administered by the correctional system, or other local, State, or Federal agencies.

III. Transitional Primary Care Services
A. Transitional primary care services are services delivered on an outpatient basis or in an outpatient setting for a brief period of time until a more permanent health care provider can be arranged, which includes a comprehensive continuum of care, such as, primary medical care and prescription drugs. These services may also include medical case management, HIV counseling and testing, and referral services to obtain health care. Ryan White HIV/AIDS Program funds may only be used for these services when other sources of funds are not available.

B. This policy does NOT generally permit the use of Ryan White HIV/AIDS Program funds in State and Federal prison facilities, since the State and Federal prison systems are responsible for providing health care services to all individuals remanded to their facility. Such care is the responsibility of law enforcement, judicial, and penal authorities in whose secure custody the individual is held. This limitation, however, does not apply to State or Federal inmates about to be released to the community and who are receiving health-related services using community resources, when not actually living in the correctional facility, such as home detention and halfway house programs.

C. Grantees wishing to institute a program of transitional primary care services in a local, State, or Federal correctional setting must either deliver these services directly or through sub-contracts with qualified HIV/AIDS community-based providers to deliver primary care services directly to eligible incarcerated persons to ensure that Ryan White HIV/AIDS Program funds are properly expended and only for services not otherwise available to any incarcerated persons.
D. Grantees can use Ryan White HIV/AIDS Program funds to support HIV/AIDS services in local (e.g., county, city) jails if these institutions are not legally responsible for meeting the HIV/AIDS health care and treatment needs of persons in their custody.

E. Grantees can use Ryan White HIV/AIDS Program funds to support primary care services for incarcerated persons who reside in the community (e.g., an individual who is not part of the prison or jail system but resides in a pre-release facility) ONLY to the extent to which services are not available or should not be reasonably expected to be available to the incarcerated person involuntarily confined. Furthermore, funding is available only to support incarcerated persons who are expected to be eligible for and the responsibility of the Ryan White HIV/AIDS Program.

IV. Timeframe
The allowable timeframe for the provision of transitional services requires flexibility to ensure the effectiveness of our programs. The determination of the exact amount of time that is required should be determined by a collaborative effort between the Ryan White HIV/AIDS Program project staff who will be involved in care during and after release and the correctional institution's medical and case management staff who are providing the care while the inmate is in custody, and based on inmate needs. While recognizing that the timeframe must be flexible and determined collaboratively, it is recommended not to exceed 180 days. The time delineation must be done in collaboration with HAB's Ryan White HIV/AIDS Program project officers.

V. Non-Covered Services
Recognizing that the determination of non-covered support or primary care services is unique to each locality, the grantee is responsible for assessing the extent to which such services are or should be covered. The grantee must delineate precisely what services will be provided by the grantee and by the correctional system that are otherwise not available.

VI. Public Resources
The grantee must assess the availability of other public resources for social support and health-related services and benefits programs in order to ensure the Ryan White HIV/AIDS Program funds remain the payer of last resort.

VII. Coordination
HAB expects that grantees will coordinate the use of funds for prison health services among publicly funded HIV-related community-based organizations across the other local, State, Federal, and public programs, in order to assure an efficient, seamless, and comprehensive continuum of HIV/AIDS care for the transition of incarcerated.
VIII. Communication
Grantees must develop methods to ensure that communication between the correctional system, the grantee, and/or qualified provider preserve and protect patient privacy and confidentiality, including the patient's right not to disclose or to have disclosed her or his HIV/AIDS status. Grantees and/or qualified providers must ensure that only those incarcerated persons who wish to receive primary care and/or transitional services are referred for participation.

IX. Reporting
The grantee must have a mechanism to report to HAB on the use of funds to provide transitional services and social services in correctional systems, and to include the individuals served in the same reporting process as other Ryan White HIV/AIDS Program service recipients for primary care services.
TO: All Ryan White HIV/AIDS Program Grantees

Attached is the HIV/AIDS Bureau’s (HAB) updated policy describing the use of Ryan White HIV/AIDS Program Part B funds for access, adherence, and monitoring services. This policy was previously published as “Policy Notice 00-02” and was amended April 26, 2001. This updated policy reflects the technical changes in Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) and establishes updated guidelines for the use of Ryan White HIV/AIDS Program Part B Funds for Access, Adherence and Monitoring Services affecting the AIDS Drug Assistance Program (ADAP). In essence, the previous policy has not undergone any substantive changes and is being re-issued to reflect the technical changes as a result of the newly reauthorized Ryan White HIV/AIDS Program, including a reference to the provision requiring States to have certain classes of core antiretroviral medications on their formularies.

On July 26, 2000, the HIV/AIDS Bureau (HAB) issued a policy clarifying how Ryan White HIV/AIDS Program funds from the ADAP appropriation could be used to provide services to increase access to medications, adherence to medication regimens, and monitoring of progress to therapy. Specifically, the Ryan White HIV/AIDS Program Section 2616(c)(6) of the Public Health Service Act contains language that permits ADAP funds to be used to "encourage, support, and enhance adherence to and compliance with treatment regimens, including related medical monitoring." However, the law places some limits on the use of ADAP funds for these purposes. It states, "Of the amount reserved by a State for a fiscal year for use under this section, the State may not use more than 5 percent to carry out services under [this] paragraph, except that the percentage applicable with respect to such paragraph is 10 percent if the State demonstrates to the Secretary that such additional services are essential and in no way diminish access to the therapeutics described in subsection 2616(a)."

HAB interprets this provision to say that the criteria for using ADAP funds for services related to access, adherence, and monitoring are still appropriate and in force, and that no more than 5 percent of a State’s ADAP funding in a given year may be used for these services unless there are extraordinary circumstances that would warrant up to 10 percent of a State’s ADAP funding being used. We have included some examples of extraordinary circumstances.
The Use of Ryan White HIV/AIDS Program, Part B, AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

In accordance with the provisions of Title XXVI of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program), the following policy establishes updated guidelines for the use of Ryan White HIV/AIDS Program funds for allowable ADAP-related expenditures. The purpose of all Ryan White HIV/AIDS Program ADAP funds is to ensure that eligible HIV-infected persons gain or maintain access to HIV-related medications. This policy continues to provide grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications. This policy further clarifies the use of ADAP funds under Section I, item A specified below.

I. Federal funds received under the Ryan White HIV/AIDS Program, ADAP, as established by Section 2612(b)(3)(B) of the Public Health Service (PHS) Act, in accordance with Section 2616 of the PHS Act, may be used for access, adherence, and monitoring services under the following conditions.

A. No more than 5 percent of ADAP funds may be used for the following services, except that under extraordinary circumstances, no more than 10 percent of ADAP funds may be used to fund: (1) enabling eligible individuals to gain access to drugs; (2) supporting adherence to the drug regiment necessary to experience the full health benefits afforded by the medications; and (3) services to monitor the client’s progress in taking HIV-related medications (refer to HAB Policy Notice 07-02, “The Use of Ryan White HIV/AIDS Program Funds for HIV Diagnostics and Laboratory Tests Policy”).

The State can use ADAP funds to purchase these services referenced only if the State demonstrates to the Secretary that such additional services are essential and in no way diminish access to the therapeutics described in subsection 2616(a) of the PHS Act.

Extraordinary circumstances may include such factors as demonstrated exceptionally low compliance and adherence rates among targeted segments of the clients receiving ADAP medications (e.g. active substance users, persons with serious mental illnesses, etc.), or significant new numbers of clients entering
ADAP who are new recipients of drug therapies (as a result of other outreach activities) that necessitate devoting added resources to these activities. The State must work with HAB to ensure that any requested use of ADAP funds for these services above 5 percent is necessary and appropriate and that existing ADAP services to clients will not be diminished or disrupted.

B. There are no current limitations to accessing ADAP in the State, including: (1) no client waiting list or limits on client enrollment; (2) no restrictions or limitation on HIV medications, such as caps on the number of prescriptions or cost to the client (such as co-pays), except for purposes of clinical quality assurance or the prevention of fraud and abuse; and (3) administrative support is maintained (e.g., administrative support and eligibility staff.)

C. There is current, comprehensive coverage of antiretroviral and opportunistic infection (OI)/preventive therapies including: (1) an ADAP formulary that includes a full complement of PHS recommended antiretroviral medications; and (2) medication necessary for the prophylaxis and treatment of opportunistic infections. Compliance with formulary coverage may be adjusted or modified based on the State’s alternative methods of providing comprehensive pharmacy coverage (e.g., health insurance, or Stated-funded pharmacy assistance program). Section 2616(c)(1) of the PHS Act requires that the State “shall ensure that the therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary under subsection (e) are, at a minimum, the treatments provided by the State pursuant to this section.” Under subsection (e) of that same section, it states “For purposes of subsection (c)(1), the Secretary shall develop and maintain a list of classes of core antiretroviral therapeutics, which list shall be based on the therapeutics included in the guidelines of the Secretary known as the Clinical Practice Guidelines for Use of HIV/AIDS drugs, relating to drugs needed to manage symptoms associated with HIV.” In a letter dated February 15, 2007 (see attachment) from Dr. Deborah Parham Hopson, Associate Administrator of HAB, Part B Program Directors were informed that the current United States PHS Clinical Practice Guidelines identify 1) Non-nucleoside Reverse Transcriptase Inhibitors; 2) Nucleoside/Nucleotide Analogues; 3) Protease Inhibitors; and 4) Fusion Inhibitors as the classes of approved antiretrovirals for the treatment of HIV infection and that all ADAPs must include agents from each of the classes in their FY 2007 formulary. (The PHS Guidelines can be found at the following website: http://aidsinfo.nih.gov/Guidelines/Default.aspx?MenuItem=Guidelines).

II. It is expected that no more than 5 percent of ADAP funds will be used to purchase services referenced in I. A, items (1) – (3) above; and up to 10 percent under extraordinary circumstances and in agreement with HAB staff.

III. In addition:

A. The grantee will work with HAB staff to ensure the grantee’s plan to redirect ADAP funds still meets the core purposes of ADAP.
B. The Ryan White HIV/AIDS Program must be the payer of last resort. Grantees must be capable of providing the HAB with documentation related to the use of funds as payer of last resort and the coordination of such funds with other local, State, and Federal funds. For example, the grantee should back bill Medicaid for Ryan White HIV/AIDS Program services provided to Medicaid eligible individuals. In addition, funds received under the Ryan White HIV/AIDS Program, including ADAP, must be used to supplement, but not supplant, funds currently being used from local, State, and Federal agency programs.

C. The grantee must have a mechanism to report on the use of redirected funds. For example, an estimation of unspent funds, including carryover, the impact of such services in improving access and use of ADAP-funded medications, and any procedural plans to shift funds back to purchasing medications.

D. The request to provide additional services with ADAP funds must be submitted on an annual basis either through the grant application process or by requesting prior approval from Resources and Services Administration’s Division of Grants Management Operations during the year.
Policy Notice – Notice 07-02

Document Title: The Use of Ryan White HIV/AIDS Program Funds for HIV Diagnostics and Laboratory Tests Policy

DATE:

TO: All Ryan White HIV/AIDS Program Grantees

Attached is the HIV/AIDS Bureau (HAB) updated policy describing the use of Ryan White HIV/AIDS Program funds for HIV diagnostics and laboratory tests. This policy was previously published as “Policy Notice 99-03.” This updated policy reflects the changes in Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) and establishes updated guidelines for the use of Ryan White HIV/AIDS Program funds for HIV diagnostics and laboratory tests for Parts A through D of the Ryan White HIV/AIDS Program.

This policy is consistent with the “Public Health Service Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents”, “Public Health Service Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection”, “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings”, and other standards, supported by professional associations.

The attached policy emphasizes the importance of diagnostics and laboratory tests as clinical tools in medical assessment and treatment decision-making, related to HIV/AIDS antiretroviral agents and other medications that treat HIV/AIDS or opportunistic infections related to HIV disease.

If you have any questions regarding the content of the HAB Policy Notice, please contact your project officer. Thank you for your attention to this important matter.

Deborah Parham Hopson, Ph.D., R.N.
Assistant Surgeon General
Associate Administrator

Attachment
Policy Notice 07-02: The Use of Ryan White HIV/AIDS Program Funds for HIV Diagnostics and Laboratory Tests Policy

The purpose of all Ryan White HIV/AIDS Program funds is to ensure that eligible HIV-infected persons and families gain and/or maintain access to medical care. In accordance with the provisions of Title XXVI of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program), the following policy establishes guidelines for the use of Ryan White HIV/AIDS Program funds for HIV diagnostics and laboratory tests.

I. Ryan White HIV/AIDS Program funds for Parts A, B (including ADAP funds), C, and D may be used by grantees for support of diagnostic and laboratory tests integral to the treatment of HIV infection and related complications (for example, but not limited to, CD4 counts, viral load tests, genotype assays) under the following conditions:

A. The tests are consistent with medical and laboratory standards, as established by scientific evidence and supported by professional panels, associations, or organizations. Types of standards include, but are not limited to:

- “Public Health Service Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents”;
- “Public Health Service Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection”;
- “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings”, and
- Other standards supported by professional associations, such as the Infectious Diseases Society of America, American Medical Association, American Pediatric Association, and American College of Obstetricians and Gynecologists.

B. Such diagnostics and laboratory tests (1) are approved by the Food and Drug Administration (FDA), when required under the FDA Medical Devices Act and/or (2) are performed in an approved Clinical Laboratory Improvement Amendments of 1988 (CLIA) certified laboratory or State-exempt laboratory.

C. Such diagnostics and laboratory tests (1) are ordered by a registered, certified, or licensed medical provider and (2) are necessary and appropriate, based on established clinical practice standards (refer to Section 1) and professional clinical judgment.

D. Ryan White HIV/AIDS Program funds are the payer of last resort by statute; therefore, grantees must demonstrate a procedural mechanism for purposes of identification and billing of liable payers. Funds for diagnostics and laboratory tests cannot be expended without such a procedure in place.

Diagnostic and laboratory tests, ordered in accordance with this policy, constitute core medical services, as that term is defined in Parts A, B, and C of the PHS Act.
Dear Colleague:

Improving access and care for American Indians (AIs) and Alaska Natives (ANs) affected by HIV disease remains important to the overall objective of Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program). The following new language in the act highlights the importance of providing access to services for AI/AN:

- Indian Health Services (IHS) Facilities or those operated by the IHS are now eligible to apply as direct grantees for Part C and Part D under the Ryan White Program (in addition to previously authorized Urban Programs and 638 Tribal Facilities under Policy Notice 00-01);
- Programs administered by or providing services of the IHS are exempt from the “Payer of Last Resort” restriction for Parts A, B, and C;
- Planning Council representation under Part A should include members from Federally recognized Indian tribes as represented in the population; and,
- Preference language was added for the AIDS Education and Training Centers (AETCs) to train health care professionals who provide treatment for “Native Americans” with HIV/AIDS.

To incorporate the new language, we are revising Policy Notice 00-01 and issuing Policy Notice 07-01, The Use of Ryan White Program Funds for American Indians and Alaska Natives and Indian Health Service Programs, to further encourage and enhance health care access and services for AIs and ANs affected by HIV disease. A companion Question and Answer guide is also attached to clarify commonly asked questions raised by organizations and AIs/ANs wanting to access the services offered through the Ryan White Program.

Please ensure that this policy is communicated and distributed to all grantees and potential providers of HIV related services for AIs/ANs affected by HIV disease. If you have further questions about this correspondence or related policies, please visit the Health Resources and Services Administration, HIV/AIDS Bureau (HAB) website at http://hab.hrsa.gov/ or contact your HAB project officer.

Sincerely,

[Signature]

Deborah Parham Hopson, Ph.D., R.N.
Assistant Surgeon General
Associate Administrator
Policy Notice 07-01: The Use of Ryan White Program Funds for American Indians and Alaska Natives and Indian Health Service Programs

The following policy establishes guidelines for allowable expenditures under Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program): 1) to provide services to American Indians and Alaska Natives (AlIs/ANs); and 2) for health care services provided by the Indian Health Service (IHS) programs directly or under contract or compact. The purpose of all Ryan White Program funds is to ensure that eligible HIV-infected persons and families gain or maintain access to medical care.

AlIs/ANs can claim Ryan White Program services for which they are eligible where they choose, regardless of the availability of services that may also be available to them (e.g., through IHS, tribal, or urban Indian health programs and services). This policy ensures that AlIs/ANs have direct and unfettered access to Ryan White Programs. In addition, this policy clarifies the circumstances under which the IHS may and may not receive funds under the Ryan White Program.

I. Coverage of American Indians and Alaska Natives under the Ryan White Program Who are Eligible for Services Provided by or Supported by the Indian Health Service

A. Any AI or AN who is otherwise eligible to receive Ryan White Program-funded services from any Part may request and must receive those services regardless of whether or not they are also eligible to receive the same services from the IHS, and regardless of whether or not those IHS services are available and accessible to the AI or AN. A Ryan White program grantee or provider cannot deny services based on AI/AN status. However, individuals must meet the same established eligibility criteria as all other individuals receiving care through a Ryan White Program-funded grantee or provider.

B. AlIs/ANs may seek care at a Ryan White Program funded facility without referral or a purchase order from the "IHS operated" or "638 contract" or compact facility. The Ryan White Program funded facility or provider should follow established procedures to determine health care coverage as it usually does as the payer of last resort program; programs administered by or providing services of the IHS are exempt from the payer of last resort restriction for Parts A, B, and C. The IHS is not obligated to reimburse a Ryan White Program grantee or provider for services provided to an AI or AN who requests services without a purchase order referral from the IHS. However, the grantee or provider must seek payment from other payers (e.g. Medicaid) first.

II. Eligibility of Indian Health Service or Tribally Operated Facilities to Receive Ryan White Program Funds

A. "IHS-operated" facilities:

1. Are not eligible to receive direct funds under Part A or B of the Ryan White Program but may apply and be awarded funds under Parts C or D as a direct grantee.

2. Are eligible to receive funds as sub-contractors under Parts A, B, C, and D, as long as the IHS-operated facility can demonstrate that the provision of Ryan White Program services to Ryan White Program eligible individuals supplements and does not supplant IHS-funded programs, and the IHS-operated facility adheres to the requirements of the grantee or provider from which the sub-contract is awarded.
B. "638 contract" facilities:

1. Parts A and B: "638 contract" facilities are not eligible to receive grant funds as a direct grantee under Part A or B of the Ryan White Program. However, "638 contract" facilities are eligible to receive funds as a subcontractor under Parts A or B of the Ryan White Program if they meet the statutory criteria as appropriate entities. Financial assistance (as a subcontractor) may be made "to public or nonprofit private entities or private for-profit entities if such entities are the only available provider of quality HIV care in the area ..." (Section 2604(b)(2) of Title XXVI of the Public Health Service Act).

2. Part C: "638 contract" facilities are eligible to receive direct grant funds under Part C of the Ryan White Program under the criteria set forth in Section 2652(a)(1)(E) of Title XXVI of the Public Health Service Act as "health facilities operated by or pursuant to a contract with the Indian Health Service."

In addition, if the tribe has (or receives) nonprofit status, it is eligible as a nonprofit private entity. A tribe is required to produce a copy of its "638 contract" with the IHS/DHHS to establish its status as owner and operator of the facility. In addition, a tribe claiming non-profit status is required to produce a letter from the appropriate Federal, State, or local entity as proof of such status.

3. Part D: "638 contract" facilities are eligible to receive direct and subcontractor grant funds under Part D of the Ryan White Program if they meet the criteria in Section 2671(a) of Title XXVI of the Public Health Service Act as "public and nonprofit private entities (including a health facility operated by or pursuant to a contract with the Indian Health Service) for the purpose of providing family-centered care involving outpatient or ambulatory care (directly or through contracts) for women, infants, children, an youth with HIV/AIDS."

4. The "638 contract" facilities and services must meet established eligibility criteria of the Ryan White Program. Thus, for Ryan White Program services provided to eligible individuals who present for services, a "638 contract" facility must serve those individuals without regard to their status as non-AI or non-AN.

C. Urban Indian Health Programs Designated by the IHS:

1. Urban Indian health programs designated by the IHS are not eligible to receive direct funds under Parts A and B.

2. Urban Indian health programs designated by the IHS are eligible to receive direct funds under Parts C and D. However, the Urban Indian health programs must meet established eligibility criteria of the Ryan White Program. Thus, for Ryan White Program services provided to eligible individuals who present for services, an Urban Indian health program must serve those individuals without regard to their status as non-AI or non-AN.

3. Urban Indian health programs designated by the IHS are eligible to receive sub-contract funds under Parts A, B, C, and D as long as they meet the established Ryan White Program criteria for those Parts, and if they meet the statutory criteria as appropriate entities. Financial assistance (as a subcontractor) may be made "to public or nonprofit private entities or private for-profit entities if such entities are the only available provider of quality HIV care in the area ..." (Section 2604(b)(2) of Title XXVI of the Public Health Service Act).

4. The Urban Indian health programs must meet established eligibility criteria of the Ryan White Program. Thus, for Ryan White Program services provided to eligible individuals who present for services, an Urban Indian health program must serve those individuals without regard to their status as non-AI or non-AN.
With the exception of programs administered by or providing services of the IHS under Parts A, B, and C, the Ryan White Program must be the payer of last resort. Grantees must be capable of providing the HAB with documentation related to the use of funds as payer of last resort and the coordination of such funds with the tribes and with the IHS as applicable, and other sources of payment (e.g., Medicaid, Medicare, Department of Veterans Affairs, State funded programs, etc.).
Ryan White Program and Services for American Indians and Alaskan Natives

Questions and Answers for Policy Notice 07-01

1. Are Federally-recognized American Indians (AI) and Alaskan Natives (AN) eligible to receive services funded under the Ryan White Program?

Yes. AIs/ANs can claim Ryan White Program services for which they are eligible where they choose, regardless of the availability of other services that may also be available to them (e.g., through Indian Health Service (IHS), tribal, or urban Indian health programs and services).

2. What are the eligibility criteria?

Persons infected with the Human Immunodeficiency Virus (HIV) and those who have clinically defined Acquired Immune Deficiency Syndrome (AIDS) are eligible. Some States/Territories may require additional financial, residential, and medical criteria to establish eligibility. Non-infected individuals, in limited situations, may be eligible for services but only if these services have at least an indirect benefit to a person with HIV infection.

3. Are AIs/ANs eligible for the AIDS Drug Assistance Program (ADAP) under Part B?

Yes. ADAP provides funding for medications for the treatment of HIV disease. Each State and territory establishes its own eligibility criteria. All require that individuals document their HIV status and meet established income eligibility criteria. ADAPs operate under either a pharmacy reimbursement model similar to Medicaid or may directly purchase and distribute drugs for and to enrollees. Clients can enroll in ADAP in one of two ways depending on the state of enrollment; either by applying directly through state ADAP offices or submitting applications through their case manager, physician, nurse, or other service provider.

4. If Ryan White Program services are utilized by AIs/ANs, will services accessed through IHS and other providers be limited/restricted?

There are no restrictions that prohibit clients from tailoring their health care program utilizing various providers and services for which they are eligible to meet their individual health care needs.
5. Will providing Ryan White Program services to eligible populations infringe upon existing resources meant for AIs/ANs?

Ryan White Program services cannot be denied to clients who are not AIs/ANs. By IHS law, IHS and tribal facilities who receive Ryan White Program funds, however, are not required to provide individuals whom are not AI/AN access to existing resources that are meant for AIs/ANs. As the Ryan White Program and IHS eligibility for services are separate health care programs, clients presenting for care are eligible for care/services as prescribed by each individual programs' existing eligibility rules. Those clients, who are not AI/AN, who receive services not covered by the Ryan White program from IHS-operated, 638 contract, or Urban Indian Health Programs should follow the facilities’ established procedures for determining health care coverage and payment for these services.

6. Can the Ryan White Program be used to provide additional services at facilities that already provide HIV related services?

Ryan White Program services must not supplant (replace a service already offered and available) other funded services but may be used to supplement services which are unavailable for clients who require the service.

7. If an AI/AN receives Ryan White Program-funded services from a non-IHS provider, must they obtain a referral or purchase order from IHS or a 638 contract facility to cover the costs of services provided by the non-IHS provider or grantee?

No. The IHS is not obligated to reimburse a Ryan White Program grantee or provider for services provided to an AI or AN who requests those services. IHS services are a separate entitlement from Ryan White Program services. IHS facilities are also exempt from the “Payer of Last Resort” restriction for Parts A, B, and C.

8. Who covers the cost of the services received at a Ryan White Program-funded service provider?

Ryan White Program funds cover the cost of the care. With the exception of programs administered by or providing services of the IHS under Parts A, B, and C, - who are exempt from payer of last resort restrictions - if a patient is eligible or has other health service coverage, e.g., Medicaid, the grantee or provider must seek payment from that payer first and should follow established procedures to determine health care coverage as it usually does under the payer of last resort program.
9. What services are eligible for payment under the Ryan White Program?

The Ryan White Program can cover the cost of an array of HIV/AIDS health and related supportive services. Health services can include primary health care, including the ADAP, early intervention services, and dental services. In addition, the Ryan White Program covers critical health related support services needed for individuals with HIV/AIDS to achieve their medical outcomes. Support services might include respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services.

Payment for these services must be sought from all other sources, Medicaid, private insurance, and other third party reimbursement plans, prior to grantees seeking reimbursement from the Ryan White Program. With the exception of programs administered by or providing services of the IHS under Parts A, B, and C, - who are exempt from payer of last resort restrictions - Ryan White Program funding is the payer of last resort. Grantees must be capable of providing the HIV/AIDS Bureau (HAB) with documentation related to the use of funds as payer of last resort and the coordination of such funds with the tribes and with the IHS as applicable and other sources of payment (e.g., Medicaid, Medicare, Department of Veterans Affairs, State funded programs, etc.).

10. How do IHS operated facilities, 638 contract facilities, and Urban Indian Health Programs differ in eligibility to receive Ryan White Program funds?

<table>
<thead>
<tr>
<th>Ryan White Program</th>
<th>IHS Operated Facilities</th>
<th>638 Contract Facilities &amp; Urban Indian Health Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parts A &amp; B</td>
<td>May only receive funds as a subcontractor</td>
<td>May only receive funds as a subcontractor</td>
</tr>
<tr>
<td>Parts C &amp; D</td>
<td>May receive funds as a direct grantee or subcontractor</td>
<td>May receive funds as a direct grantee or subcontractor</td>
</tr>
</tbody>
</table>

11. What is a 638 contract facility?

A 638 facility is operated by a tribal organization that is recognized by the Federal government, under a funding agreement with IHS.

12. How should a IHS operated facility, 638 contract facility, or Urban Indian Health program apply to become a Ryan White Program grantee?

Facilities, Tribes, and Urban Indian Health programs interested in applying as a direct grantee should periodically check http://www.grants.gov/ as all program guidances are released and applicants must apply electronically via this site. Interested programs should also review the necessary steps on
http://www.grants.gov/ to apply for grants and use the information provided to prepare themselves as a competitive applicant.

13. What types of facilities and/or organizations can subcontract from a grantee to provide HIV related services?

Subcontractors can include hospitals (including Department of Veterans Affairs' facilities), community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, rural health centers, homeless health centers, substance abuse treatment programs, faith based organizations, and mental health programs that can provide HIV related services. Private for-profit entities may provide services as a subcontractor if they are the only available provider of quality HIV care in the specified area.

Facilities and/or organizations interested in providing services as a subcontractor, should directly contact Ryan White Grantees. For a list of current grantees under Parts A, B, C, and D, see the grantee lists at http://hab.hrsa.gov/programs.htm.

<table>
<thead>
<tr>
<th>Ryan White Program Components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A</strong></td>
</tr>
<tr>
<td><strong>Part B</strong></td>
</tr>
<tr>
<td><strong>Part C</strong></td>
</tr>
<tr>
<td><strong>Part D</strong></td>
</tr>
<tr>
<td><strong>Part F</strong></td>
</tr>
</tbody>
</table>
February 25, 2013

Dear Colleague:

The purpose of this letter is to clarify questions and concerns raised by grantees and sub-grantees of the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) and Centers for Disease Control and Prevention (CDC) about HIV testing and linkage to care. Pursuant to the legislative intent of the RWHAP and the Administration's National HIV/AIDS Strategy (NHAS), it is imperative that individuals who are potentially eligible for RWHAP-funded services receive an accurate HIV diagnosis and are quickly linked to RWHAP-funded medical care.

In order to be eligible for RWHAP-funded medical care, patients must have a “diagnosis of HIV disease” (Sections 2604(c)(1), 2611, 2651(c)(1) and 2671(a) of the Public Health Service (PHS) Act). There is no legislative requirement for a “confirmed” HIV diagnosis prior to linkage to RWHAP-funded medical care, nor is there any specific statutory or program requirement related to the use of Western blot testing as the only means of confirmatory testing. Confirmatory testing may occur at the RWHAP-funded medical clinic. Tests to confirm the diagnosis of HIV disease could include the following:

- Positive HIV immunoassay and positive HIV Western blot
- Positive HIV immunoassay and detectable HIV RNA
- Two positive HIV immunoassays (should be different assays based on different antigens or different principles)

Having positive results from only one HIV antibody test should not be a barrier to linkage to care to a RWHAP-funded clinic, or other HIV care providers, since the majority of people receiving a positive result from a single test have HIV infection and would benefit from quick linkage to ongoing care and prevention services. For example, an individual with one positive rapid test should be counseled about the likelihood of infection and the real (although small) possibility of a false positive result. He or she should be linked at that time, to an HIV care provider to receive follow-up HIV testing and, if confirmed, medical care.

HIV testing sites that do not obtain confirmatory testing should have a memorandum of understanding with RWHAP-funded programs or other HIV care providers to facilitate the timely linkage of patients to HIV medical care and to accelerate the receipt of an appointment for those who test preliminary positive. The receiving medical clinic must be informed of the individual's unconfirmed preliminary positive HIV test result and the need for confirmation. RWHAP-funded clinics that receive such individuals may choose to arrange an abbreviated first appointment during which the individual receives counseling about HIV testing and a limited evaluation that includes confirmatory HIV testing and potentially other HIV labs.

1 These examples are for confirmation of diagnosis of HIV disease for purposes of RWHAP eligibility only. Different standards may be required for purposes of medical care in some medical settings.
HRSA and CDC follow current standards for accurate HIV diagnosis. We recognize that the HIV testing algorithm is changing based on newer lab techniques,\textsuperscript{2} and CDC is revising its HIV testing algorithm.\textsuperscript{3} Standards of HIV confirmation will continue to evolve with improving technology.

To reiterate, the overarching goal is to diagnose and quickly link persons with HIV into high quality medical care, consistent with the Early Identification of Individuals with HIV/AIDS as required in the RWHP legislation (Sections 2603(b)(2)(A)(i-iii) and 2617(b)(8)(A-E) of the PHS Act) and the National HIV/AIDS Strategy. CDC-funded HIV testing sites and RWHP-funded clinical sites that work together will help accomplish a key step outlined in the National HIV/AIDS Strategy: “Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV.”

Sincerely,

Laura W. Cheever, MD, ScM
Acting Associate Administrator and Chief Medical Officer
HIV/AIDS Bureau
Health Resources and Services Administration

Jonathan Mermin, MD, MPH
Director
Division of HIV/AIDS Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

\textsuperscript{2}Clinical Laboratory Standards Institute

Dear Colleagues:

On December 23, 2011, the Congress enacted the Consolidated Appropriations Act, 2012, Pub. L. 112-74. The law reinstates the ban on federal funding for syringe exchange programs. Consequently, funding for Syringe Services Programs (SSPs), inclusive of syringe exchange, access, and disposal, is no longer a permissible activity. Ryan White HIV/AIDS Program grantees are prohibited from using Ryan White HIV/AIDS Program funds to support SSPs. Your project officer and/or your grants management specialist will contact you in the next several weeks to renegotiate your budgets if you proposed using fiscal year 2012 funds for SSP efforts. The amount of your award will not change, but you must submit a revised budget to the Health Resources and Services Administration (HRSA).

HRSA remains committed to providing needed guidance to Ryan White HIV/AIDS Program grantees and programs regarding this statutory change and assisting you in making the necessary adjustments. If you have questions or concerns regarding these changes and how they impact your efforts, please feel free to raise these concerns with your project officer.

Sincerely,

Deborah Parham Hopson, PhD, RN, FAAN
Assistant Surgeon General
Associate Administrator
Dear Program Grantee:

SUBJECT: Guidance on the Interpretation of "Federal Public Benefit"

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, restricts access to "Federal public benefits" to qualified aliens.

In an August 4, 1998 Federal Register notice, the Department of Health and Human Services identified 31 programs that provide "Federal public benefits." The service delivery programs of the Health Resources and Services Administration are not among the 31 programs listed in the notice since it has been determined that they do not provide "Federal public benefits" as defined in Title IV of PRWORA. Therefore, these programs are not subject to the PRWORA requirement and are not required to verify the immigration and citizenship status of their patients. The Federal Register is available on GPO Access at: "www.access.gpo.gov/nara".

I am pleased to be able to provide this long awaited information to you.

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Administrator
Dear Program Grantee/State Agency:

SUBJECT: Guidance on definition of "public charge" in immigration laws

The Department of Justice (DoJ) published in the Federal Register on May 26, 1999, a Notice of Proposed Rulemaking (NPRM) that establishes clear standards governing whether an alien is inadmissible to the United States, ineligible to adjust immigration status, or has become deportable on the grounds that he or she is likely to be or is a "public charge." The Immigration and Naturalization Service (INS) also published Field Guidance in the same Federal Register, and the Department of State (DoS) has issued a cable to all embassies implementing immediately the policy set forth in the NPRM.

There has been some confusion among immigrant families and service and benefit providers regarding how the receipt of different benefits and services by immigrants and their family members will be treated for public charge purposes. The NPRM, along with the INS and DoS guidance, clarifies the limited number of benefits that may be considered by immigration officials in making public charge determinations.

The DoJ proposes to define public charge to mean an alien who has become (for purposes of deportation) or is likely to become (for purposes of admissibility or adjustment) "primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense." Cash benefits for income maintenance include the following: (1) Supplemental Security Income (SSI); (2) Temporary Assistance for Needy Families (TANF), but not including supplemental cash benefits excluded from the term "assistance" under TANF program rules or any non-cash benefits and services provided by the TANF program; and (3) State and local cash benefit programs that are for the purpose of income maintenance (often called "General Assistance" or "General Assistance Program")..

111
Assistance" but which may exist under other names). The sole exception to the focus on cash assistance is an instance in which Medicaid or a related program would meet this definition by paying for the cost of a person’s institutionalization for long-term care. The NPRM and Guidance clarify that receipt of cash welfare assistance (SSI, TANF, or State/local equivalents) cannot automatically result in a public charge inadmissability determination. The INS and DoJ officers must still apply a “totality of the circumstances” test which may include receipt of cash assistance for income maintenance purposes, but also must include several mandatory factors, including age, health, family status, assets and resources, financial status, education, and skills.

The HRSA grant programs are not listed above and are not identified in the INS or DoJ guidance as providing a cash benefit for income maintenance purposes. Accordingly, a noncitizen can receive services under these programs and such receipt will not be considered by immigration officials as part of the public charge determinations.

Because this policy area is complicated, we encourage grantees to become familiar with the NPRM and Field Guidance published in the Federal Register. We are also enclosing a short summary of the new policy and a set of frequently asked questions and answers to help grantees/agencies better understand the details of these new public charge policies and which noncitizens may be affected. These materials, as well as the DoJ regulation and the INS guidance, can be found on the HRSA website @http://www.hrsa.gov.

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Administrator

Enclosures
November 23, 2010

HIV/AIDS Bureau

Dear Ryan White HIV/AIDS Program Grantees:

The Affordable Care Act, Public Law 111-148, changed which out-of-pocket expenses count towards the Medicare Part D annual out-of-pocket threshold. Beginning January 1, 2011, AIDS Drug Assistance Programs (ADAPs) will become what the Centers for Medicare and Medicaid Services (CMS) refer to as “TrOOP (True-Out-Of-Pocket) eligible payers.” Medicare Part D Plan sponsors will be required to include Ryan White HIV/AIDS Part B ADAP expenditures covered for Part D drugs towards the TrOOP limit of Medicare Part D enrollees.

Consequently, ADAP clients who are Medicare Part D enrollees will now be able to move through the coverage gap phase into the catastrophic coverage phase when Part D covered drugs will be available at a nominal cost (e.g., copayments of $2.50 or $6.30 or 5 percent coinsurance, whichever is greater). Prior to this change, it was difficult, if not impossible, for ADAP members to reach the catastrophic phase.

The Affordable Care Act changes will allow ADAPs to calculate individual client costs that can offset the Program, and the expenditures counting towards TrOOP will be different from State to State. Medicare Part D Plans are required to coordinate benefits with other providers of prescription drug coverage, such as ADAPs, as long as the payer participates in the online coordination of benefits (COB) process. TrOOP calculations will automatically happen at the time other payer claims are adjudicated at the pharmacy or point-of-sale by using the TrOOP Facilitation Contractor. This CMS process is already utilized by some ADAPs because of the infrastructure utilized for State Pharmacy Assistance Programs (SPAPs) and other secondary payers for Medicare Part D.

Payments for incurred costs during the coverage gap must be for covered Part D drugs and paid for by a TrOOP eligible payer such as a Part B ADAP under Part B of Title XXVI of the Public Health Service Act. These costs must be flagged as being from ADAP to ensure they are counted for TrOOP. This new provision in the Affordable Care Act treats ADAP funds the same as assistance provided by SPAPs. To ensure ADAP expenses are accurately accounted for in the TrOOP calculation, the ADAPs must participate in data sharing with the CMS COB contractor. In order to participate in the COB process, ADAPs must sign a data sharing agreement with CMS and submit electronic enrollment files with specific information that will be provided to the TrOOP facilitation contractor. The enrollment file must include a unique identification number or RxBIN/Processor Control Number for Medicare Part D enrollees. The specific steps ADAPs need to take are further explained in the enclosed letter from CMS.
Counting ADAP as TrOOP will get Medicare beneficiaries through the coverage gap phase of the Part D benefit more quickly, while allowing ADAP’s limited resources to be used more effectively. We understand the importance of this provision to both Program Grantees and beneficiaries and encourage all ADAPS to develop the data systems necessary to take advantage of Part D TrOOP process in 2011. In order to help answer your questions and ensure a timely understanding of the changes, in the following weeks, the HIV/AIDS Bureau, in collaboration with CMS, will schedule a Webinar session for all Part B Grantees and ADAPs. This session will present the changes related to TrOOP and the specific technical requirements for participation.

Enclosed is a letter from CMS that includes specific technical information to the grantees, including the ADAP Data Sharing Agreement User’s Guide and frequently asked questions. If you have additional questions, please contact your project officer.

Sincerely,

Deborah Parham Hopson, PhD, RN, FAAN
Assistant Surgeon General
Associate Administrator

Enclosure
Dear Dr. Parham:

This letter provides instructions for AIDS Drug Assistance Programs (ADAPs) to ensure Part D sponsors properly track their members' true out-of-pocket (TrOOP) drug costs in accordance with section 3314 of the Affordable Care Act. Section 3314 of Affordable Care Act amended 1860D–2(b)(4)(C) of the Social Security Act (the Act) to treat ADAP drug costs as incurred costs for the purpose of applying the TrOOP limit.

These instructions will familiarize ADAPs with the Part D coordination of benefit (COB) and TrOOP facilitation real-time and batch processes. While ADAPs may adopt either approach (batch or real-time), the Centers for Medicare & Medicaid Services (CMS) highly recommends that ADAPs consider processing their Part D secondary claims in real-time at the point-of-sale (pharmacy), if they have not already done so. When ADAPs process claims at the point-of-sale, Part D sponsors are mandated by Federal statute and regulation to automatically adjust ADAP claims as a result of retroactive changes to Part D primary claims (e.g., changes to a member’s Federal low-income subsidy status). In other words, ADAPs that choose not to participate in the real-time COB process will have to pursue collection of any overpaid cost sharing instead of the Part D sponsor automatically refunding overpaid amounts.

Part D policy guidance related to the COB and TrOOP processes is detailed in regulation at 42 CFR 423.100 and 423.464, as well as Chapters 5 and 14 of the Medicare Prescription Drug Benefit Manual. CMS is currently updating the regulation to address the new ADAP policies.

Overview of the Medicare Prescription Drug Benefit (Part D) TrOOP Policy

The Medicare Prescription Drug Program (Part D) requires contracted sponsors of Part D plans to provide “qualified prescription drug coverage” to enrolled members. Regardless of the benefit structure utilized by the Part D sponsor to administer the qualified prescription drug coverage to its enrolled members, the sponsor is required to apply an annual out-of-pocket spending threshold (i.e., TrOOP limit) as part of the benefit. Once a beneficiary's TrOOP limit is met, the beneficiary enters the catastrophic coverage phase of the benefit and his/her covered Part D prescription drug costs are significantly reduced. Also, the Federal government subsidizes most
of the prescription drug claims during the catastrophic coverage stage, net the member’s nominal cost sharing. For purposes of determining when a beneficiary meets this threshold, the Part D sponsor must track each member’s unsubsidized spending or “true out-of-pocket” (TrOOP) costs against the TrOOP limit. In CY 2011, a beneficiary enters the catastrophic coverage stage when he/she incurs $4,550 in TrOOP costs.

Prior to January 1, 2011, the costs that counted towards a beneficiary’s TrOOP limit included those costs incurred by the beneficiary (or “person” on his/her behalf, including, for example, a family member or charity), costs of the Federal low-income subsidy, and costs incurred by state pharmaceutical assistance programs (SPAPs). These incurred costs must be for covered Part D drugs (Part D drugs included on the plan’s formulary or treated as being included in a plan’s formulary as a result of a coverage exception or appeal) and paid for by the beneficiary or a TrOOP-eligible entity or payer. Section 3314 of the Affordable Care Act amended 1860D–2(b)(4)(C) of the Act to treat the following costs as incurred costs for the purpose of applying TrOOP:

- Costs borne or paid by the Indian Health Service (IHS), an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or,

- Costs borne or paid for under an AIDS Drug Assistance Program (ADAP) under part B of title XXVI of the Public Health Service Act. CMS instructed Part D sponsors to begin updating their systems to ensure that TrOOP accumulators appropriately account for these costs beginning January 1, 2011.

**TrOOP Accumulation and Coordination of Benefit (COB) Process in Real-Time**

To assist Part D sponsors with correctly calculating the TrOOP amount for its members, CMS contracted with RelayHealth, a pharmacy switch, to facilitate the transfer of supplemental payer claim information to Part D sponsors. The primary function of the TrOOP facilitation contractor is to identify patient paid amounts remaining after other payers have wrapped around Part D claims so that Part D sponsors can identify these costs and accumulate TrOOP correctly for each of their members.

For the TrOOP facilitation process to work properly, Part D sponsors (or their processors), other payers, pharmacy switches (claims routers), and the TrOOP facilitator must interact to accurately track a patient’s TrOOP costs in real-time. To ensure ADAP costs are accurately accounted for in the TrOOP calculation, and to permit ADAPs to automatically receive refunds due to retroactive adjustments to claims (e.g., as the result of changes in a member’s low-income subsidy status), CMS highly encourages the ADAP to participate in real-time electronic claims processing. ADAPs must also sign a data sharing agreement with CMS and submit electronic enrollment files to CMS’ COB contractor with specific information that will be provided to the TrOOP facilitation contractor. Each ADAP enrollment file must include a unique RxBIN or RxBIN/Processor Control Number (PCN) combination for its Medicare Part D enrollees. It is the unique RxBIN or RxBIN/PCN combination that allows the pharmacy switch to route the...
ADAP secondary claims data to the TrOOP facilitator, who then provides this information to the Part D sponsors.

Using more technical terms, pharmacy claims to payers are transmitted via “B” transactions. These B transactions are submitted electronically by the pharmacy to their switch. The pharmacy switch forwards to the TrOOP facilitator the B transactions that are not rejected by the secondary payer and that contain a unique RxBIN or RxBIN/PCN combination for a plan that covers Medicare Part D beneficiaries. This identifier is the flag that pharmacy switches use to route the data to the TrOOP facilitator. The TrOOP facilitator uses the information contained in the B transaction to trigger the creation of a reporting transaction (N transaction) and delivers the N transaction to the Part D sponsor. All claims submitted to other payers must be processed through a pharmacy switch so that the pharmacy switch can deliver the transactions to the TrOOP facilitator enabling accurate TrOOP reporting at the Part D sponsor. An illustration of this process is provided in Attachment 1.

TrOOP Facilitator Batch Process

In order for the COB and TrOOP tracking processes to function as effectively as possible, ADAPs need to supply paid claims information to the Part D sponsor after making a payment that is supplemental to a Medicare payment. This will happen automatically if the ADAP participates in the real-time claims adjudication process and reports their coverage information to CMS in accordance with the processes above.

However, if the ADAP does not have electronic claims processing capability, the ADAP may alternatively submit a batch file of supplemental claims information or make arrangements to submit information in another format to the TrOOP facilitator. The supplemental claims data submitted to the TrOOP facilitator will then be supplied to Part D sponsors for TrOOP calculation. If the ADAP uses the batch process, it must still establish a unique RxBIN/PCN and participate in the data sharing exchange with CMS’ COB contractor. If the ADAP does not either support the on-line or batch process, no N transaction will be created and Part D sponsors will not be required to coordinate benefits if the claim(s) later adjust.

Further information on the batched claims process is available on the TrOOP facilitator’s website https://medifacd.relayhealth.com/Payers/MediFacD_TroopPayers.htm. Choose “Establish Batch Account” under the drop down menu.

Steps to Ensure Proper TrOOP Calculation for Part D ADAP Members

Below are the steps that should be taken by the ADAP in order to fully participate in the COB and TrOOP facilitation process:

1. Consider obtaining the services of an on-line claims processor to process claims electronically at the point-of-sale. (Not required for batch TrOOP facilitation process)
Obtaining services of a processor or Pharmacy Benefit Manager (PBM) for real-time claims adjudication is not a requirement to ensure TrOOP is calculated correctly, and CMS understands that for some ADAPs, the expense of a processor or setting up a system for real-time claims adjudication may not be worth it, especially for smaller ADAPs. However, Pharmacy Benefit Managers (PBMs) or processors are extremely knowledgeable about the point-of-sale, real-time claims adjudication process. These organizations likely participate on industry workgroups such as the National Council for Prescription Drug Programs (NCPDP) to ensure electronic claims process industry standards are followed. They will also provide the needed assistance to ensure TrOOP facilitation and claims reconciliation is performed correctly as part of the real-time process. If your ADAP would like to pursue real-time claims adjudication, we suggest the ADAP contact its State Medicaid agency or SPAP to find out if your program can contract with the same processor. The ADAP may also consult the Pharmaceutical Care Management Association (PCMA) or Pharmacy Benefit Management Institute (PBMI) for a list of member PBMs/processors.

2. Sign a data sharing agreement (DSA) and participate in the COB enrollment file exchange with CMS’s COB contractor. (Required for TrOOP facilitation)

ADAPs are required to sign a data sharing agreement (DSA) and follow the instructions contained in the attached user guide when participating in the COB enrollment data file exchange. The information the ADAP provides via its enrollment file to the COB contractor, in particular, the unique RxBIN or RxBIN/PCN, is sent to both the TrOOP facilitator and the Part D sponsors. The DSA and User Guide are found in Attachments 2 and 3.

3. Establish a unique RxBIN or RxBIN/PCN combination for their Part D members and submit this information as part of the COB contractor enrollment file exchange. (Required for TrOOP facilitation)

As explained above, the unique RxBIN/PCN allows the claim to be routed to the TrOOP facilitator so that the TrOOP facilitator may build an “N” transaction which will provide the Part D sponsor with the supplemental payer information that is necessary to calculate TrOOP correctly.

4. Ensure that the ADAP or its processor, when processing secondary claims, accepts and processes only those claims that use the same 4Rx information submitted on the ADAP’s input file (4Rx – BIN/PCN/Group ID/Member ID) to the COB contractor. (Required for TrOOP facilitation)

CMS found that when SPAPs accepted and processed claims using only some of the 4Rx information submitted on their input file to the COB contractor file, the Part D sponsor was unable calculate TrOOP correctly.
If the ADAP grantees have any questions regarding the TrOOP facilitation process, do not hesitate referring them to one of the individuals below:

Christine Hinds (TrOOP policy) (410)786-4578 or christine.hinds@cms.hhs.gov

Bill Decker (COB Data Sharing Agreement and Enrollment file exchange) (410)786-0125 or william.decker@cms.hhs.gov

Reynold Mercado (COB Contractor – GHI) 646-458-6797 or mercado@ehmedicare.com

Sincerely,

Cynthia G. Tudor, Ph.D.,
Director
Medicare Drug Benefit and C&D Data Group
Attachment 1

NCPDP v5.1 B1 Transaction Flow

First Transaction

START

Pharmacy Primary Submission → NCPDP 5.1 Claim (Real Time) → Router → NCPDP 5.1 Claim Response with Secondary Data, BIN, PCN, Group and Cardholder ID (Real Time) → Primary PDP

Secondary Payer

Note: Router represents connectivity to Payers. Pharmacy method of establishing connectivity to Payers is accomplished via direct connections or through the use of "Switch" Connectors.

Primary will obtain the BIN, PCN, Group and Cardholder from data on the eighty-bit file.

Subsequent Transaction(s)

Pharmacy Secondary Submission → Primary PDP Payment Info into NCPDP 5.1 with BIN/PCN and COB Segment (Real Time) → Router → NCOIF Facilitator → Secondary Payer Response Capture → TrOOF Facilitator → Secondary Claim Submission and Response Capture

Secondary Payer

Secondary rejects if PCN is not submitted as required by Payer Sheet. If Secondary chooses not to reject, they take responsibility to send secondary to TrOOF Facilitator.

Note: For secondary transaction, Router represents connectivity to Payer via Switch Connectors ONLY.

Last Update: 2/19/06

NOTE: For the purpose of discussions, Router = process of directing secondary/patient prescription claim to the designated payer and directing the secondary/patient prescription claim data to subsequent generation of MR Prescription Claim transactions to be sent to the primary PDP for TrOOF calculation.
ADAP DATA SHARING AGREEMENT

Supplemental Drug Program Data Sharing

USER GUIDE

For Use by State AIDS Drug Assistance Programs (ADAPs)

Version Effective Date:
July 12, 2010

INTRODUCTION

This ADAP Data Sharing Agreement USER GUIDE is the body of information and instructions state AIDS Drug Assistance Programs (ADAPs) will find useful as they implement and manage the information sharing process with CMS. In particular, the ADAP Data Sharing Agreement (DSA) and the information in this document will allow ADAPs to coordinate Medicare Part D drug benefit coverage with CMS under the terms of the Medicare Modernization Act (MMA).

PERIODICALLY, THE INFORMATION PROVIDED IN THIS USER GUIDE WILL CHANGE. As current requirements are refined and new processes developed, our ADAP partners will be provided with new and up-to-date sections of this Guide. These updated versions should replace any older versions of the Guide that you might have. Please contact the CMS should you have any questions regarding this User Guide.

If would like more general information about the current ADAP data exchange process, please E-mail william.decker@cms.hhs.gov. Remember to provide us with the E-mail address, phone number and other contact information for any individuals you would like to have added to our distribution list.

RECENT CHANGES: Updates to this edition of the User Guide

- We have revised this DSA throughout to reflect all ADAP DSA requirements current as of July, 2010.
- We have updated the section titled Contact Protocol for Data Exchange Problems; Page 21.
SECTION A: COMPLETING AND SIGNING AN ADAP DSA

Before the CMS – ADAP relationship can become operational, the potential ADAP Data Sharing Agreement partner and CMS have to sign and exchange completed copies of the ADAP Data Sharing Agreement (DSA). This section has the instructions for completing an ADAP DSA for signature.

The DSA signature package consists of two documents: The DSA itself, and the ADAP DSA Implementation Questionnaire. The DSA partner will return three signed copies of the DSA and one completed copy of the Implementation Questionnaire to CMS. CMS will not consider an ADAP DSA to be in force until the DSA partner has provided CMS with a completed copy of the Implementation Questionnaire. The ADAP DSA will be countersigned by CMS and a completed copy will be returned to the new DSA partner. Further DSA implementation procedures will also be provided at that time.

1. In the first paragraph on Page 1 of the ADAP DSA, insert all of your specific identifying information where indicated. The date that the partner completes the signature process will be entered here, and will be the “Effective Date.” However, if you wish, the date you enter may be prospective or retroactive. For example, some ADAP DSA partners prefer to enter the first day of the month in which they expect the DSA to be signed. But bear in mind that if you enter a prospective date, CMS cannot begin full implementation of the DSA until we reach it.

2. Enter the date that is requested on Page 4 of the ADAP DSA, in Section C, 1. This is the starting date for health plan enrollment information that is entered on the first regular production Initial Input File you provide to CMS.

3. On Page 9, in Section M, enter the ADAP partner’s Administrative and Technical contact information.

4. Page 9, Section N: Upon receipt of an ADAP DSA signed by the partner, CMS will provide the required Technical contact information. This does not need to be completed to execute the Agreement.

5. In the footer of the Implementation Questionnaire, Attachment C, insert the partner’s business name.

To avoid unnecessary processing delays, we strongly recommend that you use an overnight delivery service and send your signed ADAP Data Sharing Agreement copies and the Implementation Questionnaire to:

William F. Decker
Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Medicare Benefit Coordination
Mail Stop: C3-14-16
7500 Security Boulevard
SECTION B: THE ADAP DATA FILES – Standard Reporting Information

The CMS has contracted with GHI, Inc. in New York City to provide technical support for all of the data sharing partnership agreements CMS has entered into. GHI has been designated the DSA Coordination of Benefits Contractor (COBC). ADAP partners will be exchanging data files with the COBC directly, while CMS will remain responsible for overall DSA program management.

Standard Data Files: The data exchanged through the ADAP process is arranged in two different file formats (sometimes referred to as record layouts). An ADAP partner electronically transmits a data file to the COBC. This input file is the method through which the ADAP data sharing partner will submit its covered ADAP enrollee population. The COBC processes the data in this input file, then at a prescribed time electronically transmits a response file to the partner. The response file to the partner will contain Medicare Part D enrollment information for all ADAP enrollees who also have Part D.

Current versions of the Standard Data Files immediately follow. Once again we remind you that details of the information provided here are likely to change from time to time. You will be notified of any changes.

I. The Input and Response File Data Layouts

The ADAP Input File: This is the data set transmitted from an ADAP partner to the COBC on a monthly basis. It is used to report information regarding the ADAP enrollees – people who are eligible for and enrolled in an ADAP and receive coverage through such a program. We use full file replacement as the method to update eligibility files. Each month’s Input File from the ADAP will fully replace the previous month’s file. The business rules for use of the ADAP Input File immediately follow the data file layout itself.

Table 1: ADAP Input File Layout

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Size</th>
<th>Displacement</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>SSN</td>
<td>9</td>
<td>1-9</td>
<td>Numeric</td>
<td>Social Security Number – Required Populate with spaces if unavailable.</td>
</tr>
<tr>
<td>2.</td>
<td>HIC N</td>
<td>12</td>
<td>10-21</td>
<td>Alpha-Numeric</td>
<td>Medicare Health Insurance Claim Number Required if SSN not provided. Populate with spaces if unavailable.</td>
</tr>
<tr>
<td>3.</td>
<td>Surname</td>
<td>6</td>
<td>22-27</td>
<td>Text</td>
<td>Surname of Covered Individual - Required</td>
</tr>
<tr>
<td>Field</td>
<td>Name</td>
<td>Size</td>
<td>Displacement</td>
<td>Data Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>------</td>
<td>--------------</td>
<td>-----------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>4.</td>
<td>First Initial</td>
<td>1</td>
<td>28-28</td>
<td>Text</td>
<td>First Initial of Covered Individual - Required</td>
</tr>
<tr>
<td>5.</td>
<td>DOB</td>
<td>8</td>
<td>29-36</td>
<td>Date</td>
<td>Date of Birth of Covered Individual - Required CCYYMMDD</td>
</tr>
<tr>
<td>6.</td>
<td>Sex Code</td>
<td>1</td>
<td>37-37</td>
<td>Numeric</td>
<td>Sex of Covered Individual - Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0: Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1: Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2: Female</td>
</tr>
<tr>
<td>7.</td>
<td>Effective Date</td>
<td>8</td>
<td>38-45</td>
<td>Date</td>
<td>Effective Date of ADAP Coverage - Required CCYYMMDD</td>
</tr>
<tr>
<td>8.</td>
<td>Termination Date</td>
<td>8</td>
<td>46-53</td>
<td>Date</td>
<td>Termination Date of ADAP Coverage - Required CCYYMMDD – Use all zeros if open-ended</td>
</tr>
<tr>
<td>9.</td>
<td>NPlanID</td>
<td>10</td>
<td>54-63</td>
<td>Filler</td>
<td>Future use for National Health Plan Identifier. Fill with spaces only</td>
</tr>
<tr>
<td>10.</td>
<td>Rx ID/Policy</td>
<td>20</td>
<td>64-83</td>
<td>Text</td>
<td>Covered Individual Pharmacy Benefit ID for ADAP Rx ID Required if Coverage Type = U Policy Number Required if Coverage Type = V</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Rx Group</td>
<td>15</td>
<td>84-98</td>
<td>Text</td>
<td>ADAP Pharmacy Benefit Group Number</td>
</tr>
<tr>
<td>12.</td>
<td>Part D RxPCN</td>
<td>10</td>
<td>99-108</td>
<td>Text</td>
<td>Part D specific ADAP Pharmacy Benefit Processor Control Number</td>
</tr>
<tr>
<td>13.</td>
<td>Part D RxBIN</td>
<td>6</td>
<td>109-114</td>
<td>Text</td>
<td>Part D specific ADAP Pharmacy Benefit International Identification Number. Required when Coverage Type (Field 16) = U</td>
</tr>
<tr>
<td>14.</td>
<td>Toll-Free Number</td>
<td>18</td>
<td>115-132</td>
<td>Text plus “(“ and “)”) Pharmacy Benefit Toll-Free Number</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Document Control Number</td>
<td>15</td>
<td>133-147</td>
<td>Text</td>
<td>Document Control Number, Assigned by ADAP - Required</td>
</tr>
</tbody>
</table>
### ADAP Input File Layout for Part D – 249 bytes

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Size</th>
<th>Displacement</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>Insurance Type</td>
<td>1</td>
<td>149-149</td>
<td>Alpha-Numeric</td>
<td>Insurance Type - Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N: Non-qualified State Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>O: Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P: PAP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q: SPAP (Qualified – Send LIS Data)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R: Charity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>S: ADAP</td>
</tr>
<tr>
<td>18.</td>
<td>Filler</td>
<td>100</td>
<td>150-249</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fill with spaces only</td>
</tr>
</tbody>
</table>

**HEADER RECORD – All fields required**

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Size</th>
<th>Displacement</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Header Indicator</td>
<td>2</td>
<td>1-2</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘H0’</td>
</tr>
<tr>
<td>2.</td>
<td>ADAP-ID</td>
<td>5</td>
<td>3-7</td>
<td>Alpha-Numeric</td>
<td>ADAP Identifier</td>
</tr>
<tr>
<td>3.</td>
<td>Contractor Number</td>
<td>5</td>
<td>8-12</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘S0000’</td>
</tr>
<tr>
<td>4.</td>
<td>File Date</td>
<td>8</td>
<td>13-20</td>
<td>Date</td>
<td>CCYYMMDD</td>
</tr>
<tr>
<td>5.</td>
<td>Filler</td>
<td>229</td>
<td>21-249</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fill with Spaces.</td>
</tr>
</tbody>
</table>

**TRAILER RECORD – All fields required**

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Size</th>
<th>Displacement</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Trailer Indicator</td>
<td>2</td>
<td>1-2</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘T0’</td>
</tr>
<tr>
<td>2.</td>
<td>ADAP-ID</td>
<td>5</td>
<td>3-7</td>
<td>Alpha-Numeric</td>
<td>ADAP Identifier</td>
</tr>
<tr>
<td>3.</td>
<td>Contractor Number</td>
<td>5</td>
<td>8-12</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘S0000’</td>
</tr>
<tr>
<td>4.</td>
<td>File Date</td>
<td>8</td>
<td>13-20</td>
<td>Date</td>
<td>CCYYMMDD</td>
</tr>
<tr>
<td>5.</td>
<td>Record Count</td>
<td>9</td>
<td>21-29</td>
<td>Numeric</td>
<td>Number of records on file</td>
</tr>
<tr>
<td>6.</td>
<td>Filler</td>
<td>220</td>
<td>30-249</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fill with Spaces.</td>
</tr>
</tbody>
</table>

**The ADAP Response File:** This is the data set transmitted from the COBC to the ADAP partner after the information supplied in the partner’s ADAP Input File has been processed by the COBC. It consists of the same data elements in the Input File, with any corrections applied, and disposition and edit codes which let you know what we did with the record. The response will also contain new information for the partner regarding the submitted ADAP enrollees, including Medicare enrollment information if an ADAP client is found on the Medicare database.
<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Size</th>
<th>Displacement</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>SSN</td>
<td>9</td>
<td>1-9</td>
<td>Alpha-Numeric</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>2.</td>
<td>HIC N</td>
<td>12</td>
<td>10-21</td>
<td>Alpha-Numeric</td>
<td>Medicare Health Insurance Claim Number</td>
</tr>
<tr>
<td>3.</td>
<td>Surname</td>
<td>6</td>
<td>22-27</td>
<td>Alpha-Numeric</td>
<td>Surname of Covered Individual</td>
</tr>
<tr>
<td>4.</td>
<td>First Initial</td>
<td>1</td>
<td>28-28</td>
<td>Alpha-Numeric</td>
<td>First Initial of Covered Individual</td>
</tr>
<tr>
<td>5.</td>
<td>D OB</td>
<td>8</td>
<td>29-36</td>
<td>Alpha-Numeric</td>
<td>Date of Birth of Covered Individual CCYYMMDD</td>
</tr>
<tr>
<td>6.</td>
<td>Sex Code</td>
<td>1</td>
<td>37-37</td>
<td>Alpha-Numeric</td>
<td>Sex of Covered Individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0: Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1: Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2: Female</td>
</tr>
<tr>
<td>7.</td>
<td>Effective Date</td>
<td>8</td>
<td>38-45</td>
<td>Alpha-Numeric</td>
<td>Effective Date of ADAP Coverage CCYYMMDD</td>
</tr>
<tr>
<td>8.</td>
<td>Termination Date</td>
<td>8</td>
<td>46-53</td>
<td>Alpha-Numeric</td>
<td>Termination Date of ADAP Coverage CCYYMMDD *All zeros if open-ended</td>
</tr>
<tr>
<td>9.</td>
<td>NPI anID</td>
<td>10</td>
<td>54-63</td>
<td>Alpha-Numeric</td>
<td>Future use for National Health Plan Identifier</td>
</tr>
<tr>
<td>10.</td>
<td>RX ID</td>
<td>20</td>
<td>64-83</td>
<td>Alpha-Numeric</td>
<td>Covered Individual Pharmacy Benefit ID for ADAP</td>
</tr>
<tr>
<td>11.</td>
<td>RX Group</td>
<td>15</td>
<td>84-98</td>
<td>Alpha-Numeric</td>
<td>ADAP Pharmacy Benefit Group Number</td>
</tr>
<tr>
<td>12.</td>
<td>Part D RxPCN</td>
<td>10</td>
<td>99-108</td>
<td>Alpha-Numeric</td>
<td>Part D specific ADAP Pharmacy Benefit Processor Control Number</td>
</tr>
<tr>
<td>13.</td>
<td>Part D RxBIN</td>
<td>6</td>
<td>109-114</td>
<td>Alpha-Numeric</td>
<td>Part D specific ADAP Pharmacy Benefit International Identification Number</td>
</tr>
<tr>
<td>14.</td>
<td>Toll-Free Number</td>
<td>18</td>
<td>115-132</td>
<td>Alpha-Numeric</td>
<td>Pharmacy Benefit Toll-Free Number</td>
</tr>
<tr>
<td>15.</td>
<td>Original Document Control Number</td>
<td>15 t</td>
<td>33-147</td>
<td>Alpha-Numeric</td>
<td>Document Control Number, Assigned by ADAP</td>
</tr>
<tr>
<td>16.</td>
<td>COBC Document Control Number</td>
<td>15 t</td>
<td>48-162</td>
<td>Alpha-Numeric</td>
<td>Document Control Number Assigned by COBC</td>
</tr>
<tr>
<td>Field</td>
<td>Name</td>
<td>Size</td>
<td>Displacement</td>
<td>Data Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------</td>
<td>------</td>
<td>--------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17.</td>
<td>Coverage Type</td>
<td>1</td>
<td>163-163</td>
<td>Alpha-Numeric</td>
<td>Coverage Type Indicator U: Network (Electronic, Point-of-Sale Benefit) V: Non-Network (Other type of Benefit)</td>
</tr>
<tr>
<td>18.</td>
<td>Insurance Type</td>
<td>1</td>
<td>164-164</td>
<td>Alpha-Numeric</td>
<td>N: Non-qualified State Program O: Other P: PAP Q: SPAP (Qualified – Send LIS Data) R: Charity S: ADAP</td>
</tr>
<tr>
<td>19.</td>
<td>Rx Current Disposition Code</td>
<td>2</td>
<td>165-166</td>
<td>Alpha-Numeric</td>
<td>Rx Result (Action taken by COBC)</td>
</tr>
<tr>
<td>20.</td>
<td>Current Disposition Date</td>
<td>8</td>
<td>167-174</td>
<td>Alpha-Numeric</td>
<td>Date of Rx Result (CCYYMMDD)</td>
</tr>
<tr>
<td>25.</td>
<td>Part D Eligibility Start Date</td>
<td>8</td>
<td>191-198</td>
<td>Alpha-Numeric</td>
<td>Earliest Date that Beneficiary is eligible to enroll in Part D. Refer to Field 46 for Part D Plan Enrollment Date CCYYMMDD</td>
</tr>
<tr>
<td>26.</td>
<td>Part D Eligibility Stop Date</td>
<td>8</td>
<td>199-206</td>
<td>Alpha-Numeric</td>
<td>Date Beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 47 for Part D Plan Termination Date CCYYMMDD</td>
</tr>
<tr>
<td>27.</td>
<td>Medicare Beneficiary Date of Death</td>
<td>8</td>
<td>207-214</td>
<td>Alpha-Numeric</td>
<td>Medicare Beneficiary Date of Death CCYYMMDD</td>
</tr>
<tr>
<td>28.</td>
<td>Filler</td>
<td>8</td>
<td>215-222</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>29.</td>
<td>Filler</td>
<td>8</td>
<td>223-230</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>30.</td>
<td>Filler</td>
<td>3</td>
<td>231-233</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>Field</td>
<td>Name</td>
<td>Size</td>
<td>Displacement</td>
<td>Data Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------</td>
<td>------</td>
<td>--------------</td>
<td>-----------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>31.</td>
<td>Filler</td>
<td>8</td>
<td>234-241</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>32.</td>
<td>Filler</td>
<td>1</td>
<td>242-242</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>33.</td>
<td>Filler</td>
<td>1</td>
<td>243-243</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>34.</td>
<td>Filler</td>
<td>1</td>
<td>244-244</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>35.</td>
<td>Filler</td>
<td>1</td>
<td>245-245</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>36.</td>
<td>Filler</td>
<td>1</td>
<td>246-246</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>37.</td>
<td>Filler</td>
<td>1</td>
<td>247-247</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>38.</td>
<td>Filler</td>
<td>1</td>
<td>248-248</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>39.</td>
<td>Filler</td>
<td>1</td>
<td>249-249</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>40.</td>
<td>Filler</td>
<td>1</td>
<td>250-250</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>41.</td>
<td>Filler</td>
<td>1</td>
<td>251-251</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>42.</td>
<td>Filler</td>
<td>2</td>
<td>252-253</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>43.</td>
<td>Filler</td>
<td>9</td>
<td>254-262</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>44.</td>
<td>Filler</td>
<td>8</td>
<td>263-270</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>45.</td>
<td>Current Medicare Part D Plan Contractor Number</td>
<td>5</td>
<td>271-275</td>
<td>Alpha-Numeric</td>
<td>Contractor Number of the Current Part D Plan in which the Beneficiary is Enrolled</td>
</tr>
<tr>
<td>46.</td>
<td>Current Part D Plan Enrollment Date</td>
<td>8</td>
<td>276-283</td>
<td>Alpha-Numeric</td>
<td>Effective Date of Coverage Provided by Current Medicare Part D Plan CCYMMDD</td>
</tr>
<tr>
<td>47.</td>
<td>Current Part D Plan Termination Date</td>
<td>8</td>
<td>284-291</td>
<td>Alpha-Numeric</td>
<td>Termination Date of Coverage Provided by Current Medicare Part D Plan CCYMMDD</td>
</tr>
<tr>
<td>48.</td>
<td>Filler</td>
<td>8</td>
<td>292-299</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>Field</td>
<td>Name</td>
<td>Size</td>
<td>Displacement</td>
<td>Data Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>------</td>
<td>--------------</td>
<td>--------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>49.</td>
<td>Filler</td>
<td>8</td>
<td>300-307</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>50.</td>
<td>Filler</td>
<td>2</td>
<td>308-309</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>51.</td>
<td>Filler</td>
<td>2</td>
<td>310-311</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>52.</td>
<td>PBP</td>
<td>3</td>
<td>312-314</td>
<td>Alpha-Numeric</td>
<td>Part D Plan Benefit Package (PBP)</td>
</tr>
<tr>
<td>53.</td>
<td>Filler</td>
<td>3</td>
<td>315-317</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>54.</td>
<td>Filler</td>
<td>1</td>
<td>318</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
<tr>
<td>55.</td>
<td>Filler</td>
<td>99</td>
<td>319-417</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
</tbody>
</table>

**HEADER RECORD**

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Size</th>
<th>Displacement</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Header Indicator</td>
<td>2</td>
<td>1-2</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘H0’</td>
</tr>
<tr>
<td>2.</td>
<td>ADAP-ID</td>
<td>5</td>
<td>3-7</td>
<td>Alpha-Numeric</td>
<td>ADAP Identifier</td>
</tr>
<tr>
<td>3.</td>
<td>Contractor Number</td>
<td>5</td>
<td>8-12</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘S0000’</td>
</tr>
<tr>
<td>4.</td>
<td>File Date</td>
<td>8</td>
<td>13-20</td>
<td>Alpha-Numeric</td>
<td>CCYYMMDD</td>
</tr>
<tr>
<td>5.</td>
<td>Filler</td>
<td>397</td>
<td>21-417</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
</tbody>
</table>

**TRAILER RECORD**

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Size</th>
<th>Displacement</th>
<th>Data Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Trailer Indicator</td>
<td>2</td>
<td>1-2</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘T0’</td>
</tr>
<tr>
<td>2.</td>
<td>ADAP-ID</td>
<td>5</td>
<td>3-7</td>
<td>Alpha-Numeric</td>
<td>ADAP Identifier</td>
</tr>
<tr>
<td>3.</td>
<td>Contractor Number</td>
<td>5</td>
<td>8-12</td>
<td>Alpha-Numeric</td>
<td>Should be: ‘S0000’</td>
</tr>
<tr>
<td>4.</td>
<td>File Date</td>
<td>8</td>
<td>13-20</td>
<td>Alpha-Numeric</td>
<td>CCYYMMDD</td>
</tr>
<tr>
<td>5.</td>
<td>Record Count</td>
<td>9</td>
<td>21-29</td>
<td>Alpha-Numeric</td>
<td>Number of records on file</td>
</tr>
<tr>
<td>6.</td>
<td>Filler</td>
<td>388</td>
<td>30-417</td>
<td>Alpha-Numeric</td>
<td>Unused Field</td>
</tr>
</tbody>
</table>
Data Type Key

Conventions for Describing Data Values. The table below defines the data types used by the COBC for its external interfaces (inbound and outbound). The formatting standard defined for each data type corresponds to the data type identified for each field within the interface layout.

This key is provided to assist in the rules behind the formatting of data values contained within layout fields for ADAP Data Exchange Layouts.

Table 3: Data Type Key

<table>
<thead>
<tr>
<th>Data Type / Field</th>
<th>Formatting Standard</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numeric</strong></td>
<td>Zero through 9 (0 → 9)</td>
<td>Numeric (5): “12345”</td>
</tr>
<tr>
<td></td>
<td>Padded with leading zeroes</td>
<td>Numeric (5): “00045”</td>
</tr>
<tr>
<td></td>
<td>Populate empty fields with spaces</td>
<td>Numeric (5): “”</td>
</tr>
<tr>
<td><strong>Alpha</strong></td>
<td>A through Z</td>
<td>Alpha (12): “TEST EXAMPLE”</td>
</tr>
<tr>
<td></td>
<td>Left justified</td>
<td>Alpha (12): “EXAMPLE “</td>
</tr>
<tr>
<td><strong>Alpha-Numeric</strong></td>
<td>A through Z (all alpha) + 0 through 9 (all numeric)</td>
<td>Alphanumeric (8): “AB55823D”</td>
</tr>
<tr>
<td></td>
<td>Left justified</td>
<td>Alphanumeric (8): “MM221 “</td>
</tr>
<tr>
<td></td>
<td>Non-populated bytes padded with spaces</td>
<td>Text (8): “AB55823D”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Text (8): “XX299Y “</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Text (18): “<a href="mailto:ADDRESS@DOMAIN.COM">ADDRESS@DOMAIN.COM</a>”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Text (12): “800-555-1234”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Text (12): “#34 “</td>
</tr>
<tr>
<td><strong>Text</strong></td>
<td>Left justified</td>
<td>Text (8): “AB55823D”</td>
</tr>
<tr>
<td></td>
<td>Non-populated bytes padded with spaces</td>
<td>Text (8): “XX299Y “</td>
</tr>
<tr>
<td></td>
<td>A through Z (all alpha) + 0 through 9 (all numeric) + special characters:</td>
<td>Text (18): “<a href="mailto:ADDRESS@DOMAIN.COM">ADDRESS@DOMAIN.COM</a>”</td>
</tr>
<tr>
<td></td>
<td>Comma (,)</td>
<td>Text (12): “800-555-1234”</td>
</tr>
<tr>
<td></td>
<td>Ampersand (&amp;)</td>
<td>Text (12): “#34 “</td>
</tr>
<tr>
<td></td>
<td>Space ( )</td>
<td>Text (12): “AB55823D”</td>
</tr>
<tr>
<td></td>
<td>Dash (-)</td>
<td>Text (12): “AB55823D”</td>
</tr>
<tr>
<td></td>
<td>Period (.)</td>
<td>Text (12): “XX299Y “</td>
</tr>
<tr>
<td></td>
<td>Single quote (‘)</td>
<td>Text (18): “<a href="mailto:ADDRESS@DOMAIN.COM">ADDRESS@DOMAIN.COM</a>”</td>
</tr>
<tr>
<td></td>
<td>Colon (:)</td>
<td>Text (12): “800-555-1234”</td>
</tr>
<tr>
<td></td>
<td>Semicolon (;)</td>
<td>Text (12): “#34 “</td>
</tr>
<tr>
<td></td>
<td>Number (#)</td>
<td>Text (12): “AB55823D”</td>
</tr>
<tr>
<td></td>
<td>Forward slash (/)</td>
<td>Text (12): “XX299Y “</td>
</tr>
<tr>
<td></td>
<td>At sign (@)</td>
<td>Text (18): “<a href="mailto:ADDRESS@DOMAIN.COM">ADDRESS@DOMAIN.COM</a>”</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>Format is field specific</td>
<td>CCYYMMDD (e.g. “19991022”)</td>
</tr>
<tr>
<td></td>
<td>Fill with all zeroes if empty (no spaces are permitted)</td>
<td>Open ended date: “00000000”</td>
</tr>
<tr>
<td><strong>Filler</strong></td>
<td>Populate with spaces</td>
<td></td>
</tr>
<tr>
<td><strong>Internal Use</strong></td>
<td>Populate with spaces</td>
<td></td>
</tr>
</tbody>
</table>

Above standards should be used unless otherwise noted in layouts
II. The ADAP Data Exchange Process

The information following describes the data review process used by the Coordination of Benefits Contractor (COBC).

ADAP Processing Requirements

1. The System shall be able to receive an external file from an ADAP via Secure File Transfer Protocol (FTP) or a dedicated T-1 line (AGNS).

2. The System shall be able to confirm the external ADAP file format.

3. The System shall check enrollee records received on the ADAP file for the mandatory fields.

4. The System shall match enrollee records received on the ADAP file to the Benefits Master Table.

5. The System shall be able to provide information pertaining to all prescription drug coverage information for Part D beneficiaries as stored on the Part D database (the MBD).

6. The System shall be able to create and transmit a file for the MBD containing ADAP enrollees with their specific Part D plan information.

7. The system shall be able to update the Beneficiary Part D table with information received on the ADAP records.

8. The System shall be able to create and transmit a return file to the ADAP containing response records. A response record is only generated when an add, update, or delete transaction is detected. The ADAP partner will not receive response records for input records that provide no changes.

9. The System shall be able to process a full-file replacement of the ADAP records on a monthly basis.

DSA Program Description

The purpose of the ADAP data sharing agreement process is to coordinate the prescription drug benefits between Medicare Part D plans and ADAPs, as specifically required by the MMA and subsequent law. This collection of all prescription drug related benefits will facilitate the tracking of TrOOP (True Out-of-Pocket) expenses incurred by each Medicare beneficiary.

In order to coordinate benefit information, data must be collected from each ADAP on each of its enrollees. This information will be transmitted to the COBC where it will be edit-checked, and matched against Medicare Program eligibility data. When a match is found, the COBC will be able to combine the beneficiary’s ADAP information and Medicare Part D specific information to create a complete record of the beneficiary's state and federal prescription drug benefits. The combined drug benefits information will be loaded into the Medicare Beneficiary Database.
Beneficiary data will be sent from the MBD to the TrOOP Facilitation contractor and to Part D plans.

A response file will also be created to send to the ADAP. This file will contain one status record for each record initially submitted by the ADAP to the COBC. Records in the response file will indicate whether or not the ADAP enrollee is a Part D beneficiary; whether or not the COBC applied the record to the Medicare Beneficiary Database (MBD); if the record was not applied to the MBD, why (e.g., the record contained errors or the record did not provide enough information about the enrollee); what Part D plan the beneficiary is in enrolled in; and other Part D enrollment information.

Listed below are the disposition codes that the COBC may provide to each ADAP Partner in the updated Response File.

### Table 4: Disposition Codes

<table>
<thead>
<tr>
<th>DISPOSITION CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Record accepted by CMS System as an “Add” or a “Change” record.</td>
</tr>
<tr>
<td>SP</td>
<td>Transaction edit; the record is being returned with at least one edit (specific SP edits described below).</td>
</tr>
<tr>
<td>50</td>
<td>Record still being processed by CMS. Internal CMS use only; no Partner action is required.</td>
</tr>
<tr>
<td>51</td>
<td>Beneficiary is not in file on CMS System. Record will not be recycled. Individual may not be entitled to Medicare. Partner should attempt to re-verify beneficiary status based on information in its files.</td>
</tr>
</tbody>
</table>

The COBC will perform edit checks of the ADAP input file which will generate the following error codes as necessary. The COBC will supply the results to the Partner. The ADAP will be expected to correct any errors, or update any missing information on its enrollees, and re-transmit this data on the following month’s file. The SP errors that would apply for drug records are as follows:

### Table 5: SP Errors

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SP 12</td>
<td>Invalid HIC Number or SSN. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.</td>
</tr>
<tr>
<td>Error Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>SP 13</td>
<td>Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.</td>
</tr>
<tr>
<td>SP 14</td>
<td>Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.</td>
</tr>
<tr>
<td>SP 15</td>
<td>Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.</td>
</tr>
<tr>
<td>SP 16</td>
<td>Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female</td>
</tr>
<tr>
<td>SP 18</td>
<td>Invalid Document Control Number. Field cannot be blank. ADAP must assign each record a unique number in the event questions concerning a particular record arise and need to be addressed.</td>
</tr>
<tr>
<td>SP 24</td>
<td>Invalid Coverage Type. Field must contain alpha characters. Field cannot be blank or contain numeric characters. Valid values are: U: Network V: Non-network</td>
</tr>
<tr>
<td>SP 31</td>
<td>Invalid ADAP Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.</td>
</tr>
<tr>
<td>SP 32</td>
<td>Invalid ADAP Coverage Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the ADAP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.</td>
</tr>
<tr>
<td>SP 62</td>
<td>Incoming termination date is less than effective date.</td>
</tr>
</tbody>
</table>
Additionally, the COBC will provide RX specific errors:

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RX 01</td>
<td>Missing RX ID</td>
</tr>
<tr>
<td>RX 02</td>
<td>Missing RX BIN</td>
</tr>
<tr>
<td>RX 03</td>
<td>Missing RX Group Number</td>
</tr>
<tr>
<td>RX 04</td>
<td>Missing Group Policy Number</td>
</tr>
<tr>
<td>RX 05</td>
<td>Missing Individual Policy Number</td>
</tr>
<tr>
<td>RX 07</td>
<td>Missing Part D Effective date</td>
</tr>
</tbody>
</table>

**NOTE:** These are the standard error, edit and disposition codes used by the COBC for processing drug records. However, some of these codes are not applicable to the ADAP data sharing process.

**ADAP Data Processing**

1. Each month the ADAP submits an electronic input file of all enrollees to the COBC over the Internet using Secure FTP or HTTPS or via an existing T-1 line.
2. The COBC edits the input file for consistency, and attempts to match those enrollees with Medicare Part D enrollment.
3. Where the COBC determines that an enrollee on the ADAP file is a Medicare Part D beneficiary, the COBC updates that record to the CMS Medicare Beneficiary Database (MBD), which holds prescription drug coverage information on all Medicare Part D beneficiaries. The MBD will send daily updates of all prescription drug coverage of Part D beneficiaries to the TrOOP Facilitation Contractor and to the Part D plan that the beneficiaries are enrolled in.
4. The COBC then submits a response file to the ADAP via the same method used to submit the input file. This file contains a response record for each input record the ADAP submitted. The response record shows if the ADAP enrollee is a Part D beneficiary, if the COBC applied the record to the MBD, if the record was not applied to the MBD, and why (e.g., the record contained errors or the record did not provide enough information about the enrollee), in which Part D plan the beneficiary is enrolled, and other Part D enrollment information.
5. The ADAP then examines the response file to determine whether: The records were applied; the COBC was not able to match the ADAP enrollee in the CMS systems; or the records were not applied because of errors. (The ADAP must correct any records so that from subsequent full replacement input files the corrected records can be applied to the MBD.)
6. The ADAP updates its internal records on the Part D enrollment of its enrollees.
7. When the ADAP submits the next monthly full input file, it also sends corrections of all the errors from the previous submission.

**Business Rules**

1. The monthly file submitted by the ADAP is a full-file-replacement. The entire base of enrollees must be submitted each month on this file, including any corrections from the previous month’s file. Each month’s input file will fully replace the previous month’s input file.
2. One response file will be returned to each ADAP, containing a response record for each input record received. The disposition of the input record will be provided on the corresponding response record, indicating if the record was accepted.
3. The COBC will attempt to create one drug record for each ADAP enrollee record received.
4. The COBC will not send incomplete drug records to MBD; consequently, incomplete drug records will not get sent to the TrOOP facilitator.
5. The required fields for ADAP records are SSN or HICN, Surname, First Initial, Date of Birth, Sex Code, Network Indicator, ADAP Effective Date, ADAP Termination Date, Coverage Type Indicator, Insurance Type Indicator, and ADAP -ID.

**III. Establishing Electronic Data Exchange**

A number of methods of electronic data transmission are available when a partner is ready to exchange files with the Coordination of Benefits Contractor (COBC) in test or production modes. Following is an overview of the most common. The Partner’s assigned Electronic Data Interchange Representative (EDI Rep) at the COBC will address a Partner’s specific questions and concerns.

1. CMS has available two secure Internet transmission options, SFTP and HTTPS. We recommend either of these options for Partners that anticipate having a relatively low volume of data to transmit and that might find it is a burden to secure an AGNS connection. The ADAP partner's assigned EDI Rep at the COBC can advise you on this option.

2. For larger reporters CMS’ preferred method of electronic transmission is Connect:Direct (formerly known as Network Data Mover [NDM]) via the AT&T Global Network System (AGNS). Because AGNS is capable of transporting multiple protocol data streams to its members world wide, AGNS service removes the need to support a separate electronic link to each Partner. In addition, for encryption AGNS uses triple DES as its default. Use of either SNA or TCP/IP is available to submitters connected to the AGNS network. FTP via TCP/IP on either a dial or dedicated basis via AGNS is also supported.

Using hard media (e.g., CDs) for data movement or management is not permitted.

**Special Information for Small AIDS Drug Assistance Programs (ADAPs)**
We have added a data exchange option to accommodate small ADAPs, those submitting Input Files consisting of 50 or fewer records. These small ADAPs will be able to submit the Input File in a text (txt) or ASCII format. The file must still adhere to the SPAP Input File Layout for Part D – 249 bytes including the Data Type Key provided. Response files will be returned in a text (.txt) format. Refer to the SPAP Response File Layout for Part D for information on the response file. We stress that this option is only available to ADAPs submitting 50 or fewer input records.

IV. ADAP Implementation Questionnaire

The ADAP Implementation Questionnaire asks a series of questions of the data sharing partner that helps the CMS and the partner set up the data sharing exchange process. These questions are intended to help you think through some of the issues which need to be addressed before you begin the data exchange and to assure that both the CMS and the ADAP partner are in agreement as to the operational process involved. When sending their signed ADAP Data Sharing Agreement to the CMS, ADAP partners must also send a completed copy of the Implementation Questionnaire. The Questionnaire is listed as Attachment C in the included materials that accompany the Agreement sent out to new ADAP data sharing partners.

SECTION C: WORKING WITH THE DATA

I. Obtaining a TrOOP Facilitation RxBIN or RxPCN

TrOOP is the acronym for "true out-of-pocket" – spending by or on behalf of a Medicare beneficiary that counts toward the beneficiary's Part D cost sharing. ADAP partners that offer a network drug benefit (electronic at point-of-sale) are required to obtain and use a unique TrOOP facilitation RxBIN and RxPCN. These unique code numbers will identify, to the benefits coordination network, the ADAP partner’s drug benefits which are supplemental to Part D. The ADAP’s use of unique TrOOP Facilitation routing numbers will enable the TrOOP Facilitation Contractor to capture any paid claims that are supplemental to Part D and to send a copy of this information to the Medicare beneficiary's Part D Plan. The Part D Plan will use this supplemental paid claims information to help calculate the enrollee’s TrOOP. To be sure these drug claims are routed through the TrOOP Facilitation Contractor, ADAP partners must use a separate and unique RxBIN and RxPCN, in addition to their existing standard RxBIN or RxPCN codes.

If your ADAP needs to acquire a new RxBIN and RxPCN to use for TrOOP facilitation purposes you may contact either of the following two entities. The organization that issues the RxBIN is the American National Standards Institute, or ANSI. ANSI can be contacted through its Web address: www.ansi.org. The National Council for Prescription Drug Programs (NCPDP) issues the RxPCN. The NCPDP can be contacted through its Web address: www.ncpdp.org.

II. Testing the Data Exchange Process

Once the partner's ADAP DSA is in place the partner and the COBC will begin working together closely. At this point the COBC will assign the partner with its own COBC EDI Representative.
The partner's EDI Rep will be the partner's primary point of contact with the ADAP data exchange process, from testing through full production.

**Overview:** Before transmitting its first “live” (full production) input file to the COBC, the partner and the COBC will thoroughly test the file transfer process. Prior to submitting its initial Input Files, the partner will submit a test initial Input File to the COBC. The COBC will correct errors identified in the partner’s test Input Files and return test Response Files. Testing will be completed when the partner adds new enrollees in test update Input Files, the COBC clears these transmissions, and the partner and the COBC agree all testing has been satisfactorily completed.

**Details:** The partner and the COBC will begin testing as soon as possible, but no later than 180 days after the date the ADAP DSA is in effect. The population size of a test file will not exceed 1000 records. All administrative and technical arrangements for sending and receiving test files will be made during the “Preparatory Period” (see “Terms and Conditions,” Section B, of the ADAP Data Sharing Agreement).

*Testing ADAP records:* The test file record layouts used will be the regular ADAP record layouts. Data provided in the test files will be kept in a test environment, and will not be used to update CMS databases. Upon completion of its review of a test Input File, the COBC will provide the partner with a response for every record found, usually within a week, but no longer than forty-five (45) days after receipt of the test file. After receiving the test Response File in return, the partner will take the steps necessary to correct the problems that were reported on it.

In order to test the process for creating an Update File, a test “Update” will be prepared by the partner; it will "update" data on individuals included in the Test Input File. The partner shall submit the test Update File within ninety (90) days after receipt of the test Response File. The test Update File shall include any corrections made in the previous Test Response File sent to the partner by the COBC. In full file replacement, any corrections made to a file will fully replace what was previously submitted by the partner. Upon completion of its review of the test Update, the COBC will provide the partner a Response for every record on the Test Update File that matched to information in CMS databases. The COBC will provide a test Update Response File to the partner, ordinarily within a week, but no longer than forty-five (45) days after receipt of the partner’s test Update Input File.

After all file transmission testing has been completed to the satisfaction of both the ADAP Data Sharing partner and the COBC, the partner may begin submitting its regular production files to the COBC, in accordance with the provisions of Sections C and D of the ADAP Data Sharing Agreement.

**III. Using Basis for Queries**

When a partner has an immediate need to access Medicare eligibility and enrollment information, BASIS – the Beneficiary Automated Status and Inquiry System – permits a partner to make on-line queries to CMS to find out if it is possible that an individual is eligible for or enrolled in Medicare. Using a private, Web-based host, the ADAP data sharing partner can use BASIS to access Medicare Part D enrollment data. Access to BASIS will be limited to 500
queries per month. Access to BASIS is contingent on the partner having submitted its Initial Input Files and its most recent Update Files during its last quarterly production cycle.

In overview, BASIS operates as follows:

1. The COBC assigns each partner its own ADAP Personal Identification Number (“SPIN”). The SPIN delivered to the designated ADAP Contact Person within 30 days of submission of the partner’s initial Input Files. At this time, the partner will also receive information concerning the designated telephone line to be used for the BASIS application.

2. The COBC will notify the partner when the BASIS application is operational and will provide detailed instructions on how to use the BASIS application.

3. The partner will use a designated telephone line to access the BASIS application, using its assigned SPIN. For each ADAP Enrollee for whom the partner is requesting Medicare enrollment information, the partner will enter the following data elements that identify the subject of the query:
   - Social Security Number
   - Last Name
   - First Initial
   - Date of Birth
   - Sex

4. The COBC will post the results of inquiry(s) to BASIS as soon as the partner submits its inquiry(s) to the BASIS application.
IV. ADAP File Processing

On a monthly basis, ADAPs will transmit full file submissions in the file format specified in the agreement. Full file processing requires the ADAP to submit a complete file of enrollees every month. Each month’s transmitted file will fully replace the previous month’s file.

File Level Editing

Upon receipt of the ADAP Input File, the COBC performs high-level file edits to verify the format and validity of the Input File, including Header and Trailer data and record counts. The size of the ADAP Input File (that is, the number of records contained in the file) is compared to the size of the previous monthly file submitted. *With full file replacement the method for deleting enrollees is to not include previously submitted enrollee files in the current Input File.* If the most recent Input File size has less then 70% of the records included in the previous month's file, the current Input File will be placed on hold (processing will be suspended) and the COBC will ask the ADAP partner to verify that the high number of delete records in the current submission is correct before processing resumes.

The Input File is then processed at the record level. The system initially attempts to use a SSN to match to a HICN if a HICN is not submitted on the input file. The system will also determine if an incoming enrollee record is an add, update, or delete, or if no action will be taken.

**Adds**

Once a HICN is identified, the incoming record is compared to CMS databases to match on previously submitted records. The initial matching criteria consist of the HICN, plus the Effective Date of ADAP eligibility, the Insurance Type, and the ADAP ID. If a match of these fields cannot be located on the database, the incoming record is considered an "add."

**Updates**

If the incoming record matches on these fields, additional fields are compared to determine if the incoming record should be considered an update. These fields include RX ID, RX Group, Part D RxPCN, Part D RxBIN, Toll-Free Number, Coverage Type, and Termination Date. If any of these fields have changed from the previous month's submission the record is considered an "update."

**Deletes**

*Any records that were part of the previous month's file, but that are not included in the current month's submission, are processed as deleted records.*

**Deletes should only be used to remove a record that never should have been sent to CMS in the first place.** Routine Input Files should contain records of all ADAP Enrollees whose ADAP enrollment terminated up to twenty-seven (27) months prior to the first day of the month in which the Input File is generated, or whose ADAP enrollment terminated after December 31,
2005, whichever date is most recent. Failure to continue submitting these older valid records will cause them to be erroneously deleted from the CMS database.

Errors

Records containing errors are returned to the ADAP with the error code given in the error number field on the response record. The ADAP will correct the error and resubmit the record on the next month's file.

Notification to the Medicare Beneficiary Database (MBD)

After ADAP Input File processing is completed a separate new file is created and transmitted to the MBD. It contains the add, update, and delete records generated by the COBC from the Input File submitted by the ADAP. After processing this input file the MBD sends a response file to the COBC containing Part D enrollment information on ADAP clients who matched to CMS databases.

Response files

Within 15 days of the ADAP input file submission, the COBC generates and transmits a response file to the ADAP. The file contains responses for any records that were added, updated, or deleted. The file does not contain responses for records where no change was made. However, the response file will also contain new or updated Part D enrollment information for all records, even those resubmitted as unchanged.

V. The Distinction between Part D Eligibility and Enrollment

Some of our data sharing partners have expressed confusion regarding the difference between Part D Eligibility Start and Stop Dates and Current Part D Plan Enrollment and Termination Dates they receive on their response files. While many use these terms interchangeably, these terms have distinct meanings for the CMS data exchange process. To clarify:

Part D Eligibility Start Date: This refers to the first date a beneficiary can enroll in a Part D Plan. It does not mean that the beneficiary has actually enrolled yet, just that through their current Part A or B coverage that they can (they are able to) enroll in a Part D Plan.

Part D Eligibility Stop Date: Refers to the date that the beneficiary is no longer eligible to enroll and receive coverage from any Part D Plan.

Current Part D Plan Enrollment Date: Refers to the start date of Part D coverage for an eligible Medicare beneficiary that has applied for, enrolled, and now has coverage through a Part D Plan.

Current Part D Plan Termination Date: Refers to the date that beneficiary is no longer enrolled in and receiving benefits through a Part D Plan.
In the response files CMS sends you, the Current Part D Plan Enrollment Date provides the effective date of coverage for the Part D benefit by the specific Part D Plan listed as the Current Medicare Part D Plan Contractor Number. The Current Part D Plan Termination Date is the date that beneficiary is no longer receiving benefits under that Part D Plan. These dates are the most important for our data sharing partners because they let you know whether the beneficiary has actually elected coverage under Part D and the time period in which the Part D coverage became effective. In summary, a Medicare beneficiary can be eligible for Part D, but unless the beneficiary is enrolled in a Part D Plan, the beneficiary is not receiving Part D benefits.

VI. Contact Protocol for Data Exchange Problems

In all complex electronic data management programs there is the potential for an occasional breakdown in information exchange. If you have a program or technical problem involving VDSA data exchange, the first person to contact is your own EDI Representative at the COBC. Your EDI Rep should always be sought out first to help you find solutions for any questions, issues or problems you have.

If after working with your EDI Rep, you think your problem could benefit from help at a higher level, please contact the EDI Supervisor, Jeremy Farquhar, at 646-458-6614. His email address is jfarquhar@ghimedicare.com.

If you feel further escalation is necessary, contact the EDI Manager, Bill Ford, at 646-458-6613. Mr. Ford’s email address is wford@ghimedicare.com.

The COBC Project Director, with overall responsibility for the EDI Department, is Jim Brady. Mr. Brady can be reached at 646-458-6682. His email address is JBrady@ghimedicare.com.
SECTION D: FREQUENTLY ASKED QUESTIONS

ADAP DATA SHARING AGREEMENT

TABLE OF CONTENTS

General .................................................. 25

Data Specific Questions ......................... 26

General Questions

Q1: When will an ADAP ID be assigned?

A1: The ADAP ID will be assigned by the COBC it has received a copy of the signed DSA
from the ADAP data sharing partner.

Q2. Is there a possibility of receiving overlapping enrollment or multiple Prescription
Drug Plan (PDP) information on a beneficiary?

A2: CMS will not send multiple records on a beneficiary. ADAPs will receive one record,
containing the most recent information available for that beneficiary. If a beneficiary is
with one PDP at the beginning of the month, then changes to another PDP mid-month,
CMS will send information about the most recent PDP enrollment.

Q3: The COBC-ADAP data exchange is a monthly process. What is the schedule for
this process? Will the data exchange happen at the beginning, middle or end of
month?

A3: The file receipt schedule is agreed to by the ADAP and the COBC. All ADAPs do not
need to be on the same schedule. The COBC will work with each ADAP partner during
the Preparatory Period to set up a reporting and data production schedule.

Q4: Why is it necessary for the ADAP to send records on beneficiaries for up to 27
months after eligibility has been terminated in the ADAP?

A4: If a record is sent one month, but not the next, the record of that beneficiary will be
deleted from the CMS databases. Recall that the ADAP should only delete a record that
should not have been added in the first place. 27 months is the period of time a Medicare
claim can be filed after the last date of service.
Q5: In our state we have two ADAPs, one that has about 7,200 clients while the other has fewer than 600 clients. For the sake of minimizing paperwork and maximizing efficiency, can we combine these two programs for the purposes of the ADAP - CMS data sharing agreement?

A5: Yes, for administrative efficiency you could combine the two programs into one data exchange program. For the actual data exchange, however, we will assign you two different ADAP IDs, so that a Part D Plan can differentiate between the two programs if it needs to. We can take the files from the same source at the same time, but both sets would need to be separated from each other with unique headers and trailers.

Q6: With regard to the Administrative and Technical contacts needed for the ADAP - CMS data exchange, must either or both of these contacts be “State” staff or may they be “Contractor” staff?

A6: The State can designate whomever they wish to be the administrative and technical contacts, including contractor staff, but only a duly authorized representative of the State can sign the actual ADAP Data Sharing Agreement.

Q7: What are the requirements that must be met in order to successfully complete the testing of the ADAP data sharing exchange?

A7: For the ADAP partner the minimum CMS requirements are to be able to: (1) submit an initial test Input File that can be processed to the satisfaction of the COBC; (2) receive and process a test Response file from the COBC, and; (3) be able to submit a test update file to the COBC. The COBC has the authority to determine whether or not the ADAP partner has successfully completed testing and can move on to production data exchange.

Data Specific Questions

Q1: When the ADAP submits the next monthly full input file, it also sends the corrections of all the errors from the previous submission. Are we sending the full file (all ADAP eligible enrollees)?

A1: Yes, you would send a complete full file replacement.

Q2: Should we exclude previously matched records?

A2: No, you must include previously matched records.
Q3: Are “errors” just data discrepancies (e.g., a mismatched HICN and SSN)?

A3: Errors encompass a number of anomalies. They can be data that is intrinsically defective or that contains an invalid value, such as an alpha character in a field requiring a numeric, or the error could be due to a programming mistake. In such case, the Response File will identify the particular error for the ADAP, using our standard error codes.

Q4: Will we be receiving only Medicare Part D enrollment information, or will we receive information on all the other sources of prescription coverage carried by the enrollee?

A4: You will receive only Medicare Part D enrollment information for your ADAP clients. We are not permitted to identify other sources of coverage.

Q5: What field identifies Medicare D enrollment?

A5: The Current Medicare Part D Plan Effective Date (field 46 in the ADAP Response File Layout) provides current Medicare Part D enrollment information.

Q6: What field identifies the Medicare D insurer?

A6: The Current Part D Plan Contractor Number (field 45 in the ADAP Response File Layout) identifies the particular Part D plan the beneficiary is enrolled in.

Q7: We currently do not mandate collection of an SSN from the participant, although most of our participants have an SSN. In the cases where we do not have a SSN, should we just send the other information we have on the input file? If so, do we zero fill the SSN data field or leave it blank?

A7: We must have either the Medicare Health Insurance Claim Number (HICN) or the SSN for every individual you submit in order to be able to determine their Medicare entitlement information. If you do not have either one of these numbers to include on a particular individual's record you should not submit that record.

Q8: Is the Part D RxBIN and RxPCN the information that is identifying the Part D Plan (carrier) or is it being used to identify other insurance as well?

A8: This information does not identify the Part D Plan. The Part D RxPCN and Part D RxBIN – usually known as the TrOOP RxBIN or TrOOP RxPCN – are code numbers used to enable electronic routing of network pharmacy benefit information. While an ADAP might already have a standard RxBIN or RxPCN to help electronically pay network claims, a separate Part D specific RxBIN or RxPCN is required for the support of the TrOOP facilitation process. These Part D-specific code numbers are used to permit the TrOOP Facilitator to capture and route claims that have been paid secondary to Part D.
Q9: What does "network" refer to? Is it a type of coverage, such as HMO or PPO?

A9: "Network" in this context refers to computerized electronic data interchange (EDI). Specifically, it is the EDI system that providers and payers use to move claims information. The health care billing transaction site – often at the point of sale, such as a pharmacy – is a common entry point to the claims transaction network.

Q10: What does the "disposition code" identify? Is this simply a “Yes or No” indication of something like coverage on the MBD?

A10: The disposition code lets you know what action the COBC has taken regarding a submitted record. For instance, if the record is not found on CMS databases, the COBC will provide the ADAP partner with a disposition code that indicates that fact. Additionally, if a record is not applied because it contains errors, the cause is shown in the disposition code.

Q11: You've added Plan Benefit Package (PBP) to the response file. Is the three byte PBP code unique? Also, we have determined that we will need the PBP enrollment start and end dates. We request that this information be added to the data exchange Response file.

A11: PBP information (Field 52 of the ADAP Response File Layout) is now provided. There is no intrinsic logic to the PBP number and it cannot be used alone as an identifier. It is only useful when used in conjunction with the PDP’s contractor number. We cannot provide a start and stop date for the PBP. If the PBP code changes, ADAPs will receive the new PBP number to be used with the original PDP contractor number, but the PDP coverage dates will not change. ADAPs can program to note the changed PBP ID number and then input the new PBP start date.

Q12: Are PDPs eligible for the NPlanID?

A12: The "National Health Plan Identification" – or NPlanID – field is available as a placeholder for anticipated future use. All payers of health care coverage, including Medicare HMOs and Part D Plans will be required to use an NPlanID when it is eventually implemented. But the field is not used at this time.

Q13: Will the COBC ADAP response files include retroactive eligibility/enrollment information for a beneficiary?

A13: Yes, but the earliest Part D Plan enrollment date is 01/01/06.

Q14: What is the difference: COBA ID vs. ADAP ID vs. Contractor ID?

A14: The ADAP ID is your own DSA ID number. A COBA ID is used by our COB partners that have claims processing "crossover" agreements with us. A state agency (usually Medicaid) that has both a COBA and ADAP DSA with CMS would have both a COBA
ID and an ADAP ID, but the two IDs could not be used interchangeably. The Contractor ID number (Field 45 in the ADAP Response File) is the code number (ID) assigned by CMS to approved Part D Plans.

Q15: The data layout indicates space for four Rx error codes, yet the user guide lists six Rx error codes, and several error codes starting with SP.

A15: The Response File has space for only four error codes. These fields may contain either the SP or the RX error code. CMS does not anticipate that an ADAP partner will ever receive more than 4 error codes for a particular individual.

Q16: Will BASIS access be available immediately?

A16: BASIS access is provided after the partner has signed the DSA and production file exchanges have begun. BASIS is described in this User Guide, and complete information about the program is included in the welcome packet which is sent by the COBC once the partner's agreement is in place.

Q17: Is the new TrOOP RxBIN or RxPCN for our Medicare Part D claims payments the RxBIN/RxPCN that we will always be sending in the monthly input? In what circumstances would we not know what the correct RxBIN/RxPCN would be?

A17: We need your Part D specific RxBIN and or RxPCN in order to pass TrOOP data on to the TrOOP facilitator and the Part D Plan. Since you will not necessarily know which of your enrollees are Medicare beneficiaries, we are asking you to populate the TrOOP RxBIN and RxPCN fields with the Part D specific TrOOP RxBIN or RxPCN for those individuals as if they were Part D beneficiaries. As described earlier, you have to designate your TrOOP Rx BIN or RxPCN to the COBC in the Implementation Questionnaire.

Q18: Are we to send all of the ADAP enrollees in the input file (including non-Medicare clients), or only those who have told us that they have Medicare and therefore are eligible for a Part D plans?

A18: You send all of your enrollees. We respond with data indicating: Those that Medicare matched on and that we applied to our databases; those we matched on but didn't apply because of errors in the record you supplied; or those who we could not match on and who therefore are not Medicare beneficiaries. We do not expect you to know who among your clients are Medicare beneficiaries or enrolled in a Part D Plan. Essentially, the files you send us are finder files.

Q19: Is there any indicator on the response file that tells us if a person is ineligible for Part D and a reason? I think that there are various reasons for being ineligible. There would be some that do not have Medicare Parts A or B but there would also be those whose employers accepted the subsidy and they cannot enroll. How would we determine this?
Generally, someone who is a Medicare beneficiary and enrolled in Part A or Part B (or both) is eligible to enroll in Part D. Even if the beneficiary is part of a group for which an employer is claiming the employer subsidy the beneficiary is still permitted to enroll in a Part D Plan – although that beneficiary would then almost surely lose his or her employer-sponsored coverage.
This Data Sharing Agreement (the "Agreement") for the exchange of enrollment information is entered into between [Insert Data Sharing Partner Name], with its principal address at [Insert Data Sharing Partner Address of Record] and the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services ("CMS") (the "Parties") on this ___th day of __________, 20__ (the "Effective Date").

RECITALS

I. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Subsequent Regulations, and Their Impact on Supplemental Drug Program Data Sharing Partners

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was enacted in 2003. It includes a prescription drug benefit, referred to as Medicare Part D. Part D insurance plans, which include private prescription drug plans (PDPs) and Medicare Advantage plans (MAPDs), administer the Medicare Part D prescription drug benefit. The MMA introduced a concept called “true out-of-pocket” (TrOOP) costs. TrOOP refers to the incurred out-of-pocket costs a Medicare Part D beneficiary must spend in a calendar year on Part D covered drugs in order to reach the Part D catastrophic coverage threshold. Any payments made by an ADAP, as defined in Section IV, on behalf of a Part D-enrolled beneficiary supplement the Part D Plan benefit. For the Part D-enrolled beneficiary these ADAP supplements are considered incurred costs and therefore count toward the beneficiary’s Part D TrOOP. The Part D Plan has the responsibility to keep the record of the Plan member’s TrOOP spending. As a consequence, Part D Plans require up-to-date, validated information about financial support of the benefits being provided to an enrollee in the Part D Program.

II. Purpose of the Agreement

The purpose of this Agreement is to establish conditions under which (1) an AIDS Drug Assistance Program (ADAP) Data Sharing Partner, as defined in Section IV, agrees to provide prescription drug coverage data to the CMS, as more specifically set forth in Attachment A and in the User Guide; and (2) the CMS agree to provide the Data Sharing Partner with Medicare Part D enrollment data, as more specifically set forth in Attachment B and the User Guide, on Enrollees for whom the ADAP Data Sharing Partner provides prescription drug coverage.
ADAPs that offer prescription drug coverage that supplements Medicare Part D are to be included in the point-of-sale coordination of benefits process which was developed to support administration of the Medicare Part D benefit. As a result, there is a need by both Medicare and ADAPs to exchange beneficiary eligibility information. This will facilitate the coordination of benefit coverages among the programs and help to assure accurate TrOOP accounting. The parties to the agreement seek to more efficiently coordinate the payment of prescription drug benefits and premiums with Medicare Part D plans in accordance with applicable law and regulations.

III. ADAP Data Sharing Agreement User Guide

An "ADAP Data Sharing Agreement User Guide" has been produced to accompany this Agreement, and is incorporated herein by reference. This ADAP User Guide is designed to also accommodate the ordinary process changes and revisions that result from monthly program operations. Current operational versions of the input and response data illustrated in Attachments A through C can be found in the User Guide.

IV. Definitions

1. “AIDS Drug Assistance Program (ADAP)” – a program funded under the Ryan White Care Fund and administered by state governments which provides drug coverage assistance for HIV/AIDS patients.

2. “Covered Individual” – an individual who is eligible for and enrolled in an ADAP and who receives coverage through such a plan.


4. “Medicare Part D Enrollee” – a Medicare beneficiary who is enrolled in a Medicare Part D Plan and who receives Part D Plan coverage.

5. “Medicare Part D Plan” – a PDP or MAPD, a Medicare Pace Plan which includes qualified prescription drug coverage, or a Medicare Cost Plan offering incorporating prescription drug coverage.

6. “TrOOP Facilitation RxBIN or RxPCN” – unique code numbers used in the electronic network routing of pharmacy claims information. “TrOOP Facilitation” codes are used by network pharmacy payers to identify benefit coverage that is supplemental to Medicare Part D.

7. “Standard RxBIN or RxPCN” – unique code numbers used in the electronic network routing of pharmacy claims information. “Standard” codes are used by network pharmacy payers to identify their own primary benefit coverage.
8. “Agent” – an individual or entity authorized by the Data Sharing Agreement partner to act on the partner’s behalf for purposes of administering this Agreement. All actions undertaken by the agent in administering this Agreement on behalf of the data sharing partner shall be binding on the data sharing partner.

V. Terms and Conditions

In consideration of the mutual promises and representations set forth in this Agreement, the Parties agree as follows:

A. Medicare Part D Enrollment Determination for ADAP Covered Individuals

In accordance with the process described in “C,” below, the AIDS Drug Assistance (ADAP) Data Sharing Partner shall identify those ADAP covered individuals, as defined in Section IV of this Agreement, and the CMS shall identify the ADAP covered individuals who are Medicare Part D enrollees. The ADAP Data Sharing Partner further agrees that a completed copy of the ADAP Implementation Questionnaire will accompany the copies of this agreement delivered to CMS.

B. Preparatory Period and Test Procedures for Continuing Electronic Data Exchange for ADAP Covered Individuals

Within ten (10) business days after the effective date of the Agreement, the CMS, the CMS Coordination of Benefits Contractor (COBC) and the ADAP data sharing partner will begin to discuss the operational terms of the Agreement. This shall include discussions on data requirements, file submissions, review of error codes and any other issues. This Preparatory Period shall be completed within thirty (30) business days after the effective date of the agreement. If the ADAP Data Sharing Partner is unable to meet the specified timeframe of the Preparatory Period, the ADAP Data Sharing Partner shall notify the CMS in writing of this delay. Within five (5) business days of receipt of this notice from the ADAP Data Sharing Partner, the CMS will contact the ADAP Data Sharing Partner to agree on a mutually acceptable time frame in which to complete the Preparatory Period.

Prior to submitting its Initial Input File, the ADAP Data Sharing Partner shall conduct tests of its ability to provide to the CMS a “Test” Initial Input File, receive a “Test” Response File, and correct errors identified in the Test Initial Input File and add new ADAP Data Sharing Partner Covered individuals in a “Test” Monthly Input File. This Test process is described in detail in the User Guide.

After successfully completing the Test process, the Initial Input File shall be submitted in accordance with the provisions of Section C hereof.
C. Continuing Electronic Data Exchange for ADAP Covered Individuals

1. Within forty-five (45) days of the completion of the process described in Section B hereof (the "Preparatory Period"), the ADAP Data Sharing Partner shall provide to the CMS a file containing the data elements listed in Attachment A, in the record layout prescribed in the User Guide, with respect to ADAP covered individuals ("Initial Input File"). The data provided by the ADAP in the Initial File shall cover all the periods of coverage for the above-mentioned ADAP covered individuals from [insert date] through the first day of the month following the Initial File Date.

2. The CMS shall search its Medicare enrollment files for the ADAP covered individuals identified on the ADAP’s Initial Input File. Where a match occurs, the CMS shall annotate its Medicare Part D enrollment files to identify the ADAP as a supplemental payer to the Medicare Part D plan for these ADAP covered individuals.

3. Within fifteen (15) days of the CMS's receipt of the ADAP’s Initial Input File, the CMS shall provide to the ADAP a file containing the data elements listed in Attachment B, in the record layout prescribed in the User Guide, for individuals identified under the electronic match conducted pursuant to ¶ B.2 ("Response File").

4. Within fifteen (15) days of the ADAP’s receipt of the CMS’s Response File, the ADAP shall submit the next monthly Input File, having:

   a. examined the Response File to determine whether the CMS was able to apply the ADAP’s prescription drug coverage contained in the Input Records to the CMS enrollment files;

   b. examined the Response File to determine whether there were errors in the Input Records that prevented the CMS from determining the Medicare Part D enrollment of the ADAP’s covered individuals or from applying the ADAP’s prescription drug coverage contained in the Input Records to the CMS enrollment files;

   c. corrected all errors contained in the Input Records so that the CMS can determine the Medicare Part D enrollment of the ADAP’s covered individuals and apply all ADAP prescription drug coverage contained in the Input Records where the ADAP’s covered individual was identified as a Medicare Part D enrollee in subsequent Input Files; and

   d. updated the ADAP’s internal records with all corrections made by the CMS during processing of the Input File and by the ADAP after receiving the Response File.

Monthly Input Files shall contain records of all ADAP covered individuals whose ADAP enrollment terminated up to twenty-seven (27) months prior to the first day of the month.
in which the Monthly Input File is generated, or whose ADAP enrollment terminated after December 31, 2005, whichever date is most recent.

D. Correction of Error Records

Upon receipt of the ADAP’s Initial and Monthly Input Files, in the course of its standard processing activity the CMS shall analyze the files to identify any errors and defects in the data provided (e.g., data that is not readable or data that does not comply with the terms of the Agreement). If it detects errors and/or defects with submitted data, in the regular Response File the CMS shall provide to the ADAP the data elements listed in Attachment B and in the record layout prescribed in the User Guide, and will identify the errors detected on the Initial or Monthly Input Files. The ADAP shall undertake the steps necessary to correct any error records identified in a Response File, provided such records can be corrected by the Parties, and resubmit the corrected records on the next Input File.

E. RxBIN and RxPCN Codes

Both the RxBIN and RxPCN are codes used in the electronic routing of pharmacy benefit reimbursement information. The prescription Benefit Identification Number (RxBIN) and the pharmacy benefit Processor Control Number (RxPCN) are assigned to network pharmacy payers by national standards setting organizations. All point-of-sale network pharmacy payers have an RxBIN. Many, though not all, also have an RxPCN. The Input and Response Files used by the ADAP Data Sharing Agreement program include data fields for RxBIN and RxPCN reporting.

To participate in the TrOOP Facilitation process, ADAPs must obtain a unique, TrOOP-specific RxBIN or RxPCN number to code for coverage that is supplemental to Medicare Part D. This unique coding will assure that a copy of the supplemental paid claim is captured by the TrOOP Facilitation Contractor as the claims data moves through the health care billing and reimbursement EDI networks. “TrOOP Facilitation” RxBIN(s) and RxPCN(s) are required, and must be separate and distinct from the ADAP’s standard RxBIN(s) and RxPCN(s).

On an Input file, when CMS identifies an ADAP-covered individual as a Medicare Part D enrollee, the prescription drug coverage and TrOOP Facilitation RxBIN and RxPCN routing information will be made available to the Part D Plan and the TrOOP Facilitation Contractor. By signing this Agreement, the ADAP agrees to obtain a TrOOP Facilitation RxBIN or RxPCN. In addition, the ADAP must provide CMS with a list of all its Standard and TrOOP Facilitation RxBINs and RxPCNs no later than ten (10) business days prior to the submission of the Initial Input File. (See Number 13, in Section O.)

F. Beneficiary Automated Status Inquiry System (BASIS)

When an ADAP has an immediate need to query for Medicare Part D enrollment, the BASIS application allows the ADAP to make a limited number of on-line queries of the Medicare Part D enrollment of its ADAP covered individuals using a private web-based host. Access to BASIS is contingent on the ADAP having submitted its Initial Input File and its
Monthly Input File during the last monthly production cycle. Refer to the ADAP User Guide for a detailed description of the BASIS application and its operation.

G. Duty to Obtain Data

The ADAP may be in possession of some, but not all, of the data elements identified in Attachment A and the User Guide. With respect to data not now in its possession, the ADAP shall use its best efforts to obtain such data as soon as reasonably possible. With respect to data not now in its possession or incorrect, where the data cannot be obtained because an enrollment, re-enrollment or renewal date of the ADAP will not occur in the next six (6) months, the ADAP shall individually contact each program client from whom data is missing or incorrect, to obtain or correct such data within thirty (30) days of becoming aware, or being notified, that the information is missing or is incorrect. The ADAP shall include data corrections received in response to such contact in the next Monthly Input File delivered to the CMS.

If, after following the procedures detailed above for collection/correction of data, the ADAP is still unable to obtain a certain data element, excluding the Social Security Number or Medicare Health Insurance Claim Number, one of which is always mandatory, the ADAP should still provide the CMS with as many of the other data elements as it can obtain for the program client. The ADAP shall follow up requests for data that remain unresolved for more than thirty (30) days.

H. Term of Agreement

The ADAP and the CMS are dedicated to developing and implementing a process for exchanging data that provides the CMS with monthly Input Files and the ADAP with monthly Response Files on a regular and consistent basis with minimal interruption to the administration of the ADAP or CMS. Accordingly, the initial term of this Agreement shall be twenty-four (24) months from the Effective Date unless earlier terminated as set forth below, and shall automatically renew for successive twelve (12) month terms unless, not less than ninety (90) days prior to the end of any term, a Party provides the other Party with written notice of its intent not to renew the Agreement. During the initial term of the Agreement, the parties shall diligently and in good faith evaluate the data exchange process and discuss and endeavor to implement modifications to the process in order to achieve the efficiency described in Section II hereof as a principal purpose of the agreement.

During the initial term or any succeeding term of this Agreement, the CMS may terminate this Agreement upon sixty (60) days prior written notice to the ADAP of the ADAP’s repeated failure to perform its obligations pursuant to this Agreement, and the ADAP’s failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.

During the initial term or any succeeding term of this Agreement, the ADAP may terminate this Agreement upon sixty (60) days prior written notice to the CMS of the CMS's repeated failure to perform its obligations pursuant to this Agreement, and the CMS's failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.
Except as the parties may otherwise agree, this Agreement shall terminate in the event of enactment of any new Medicare Part D legislation which contradicts or is inconsistent with the terms of the data exchange portions of this Agreement.

I. Safeguarding and Limiting Access to Exchanged Data

The Parties agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this Agreement. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained under this Agreement shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The ADAP shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by the CMS. The ADAP agrees that the authorized representatives of the CMS shall be granted access to the premises where the Medicare data is being kept for the purpose of inspecting security arrangements and confirming whether the ADAP is in compliance with the security requirements specified above.

Access to the records matched and to any records created by the matching process shall be restricted to authorized employees, agents and officials of the CMS and the ADAP who require access to perform their official duties in accordance with the uses of the information as authorized in this Agreement. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

The CMS and the ADAP agree to limit access to, disclosure of and use of all data exchanged between the Parties. The information provided may not be disclosed or used for any purpose other than to implement the Part D coordination of benefits provisions of the MMA and subsequent applicable law and regulations, and coordinate benefit payments between the ADAP and the Medicare Part D plans. The Parties agree that the enrollment files exchanged by the Parties shall not be duplicated or disseminated beyond updating the Parties’ current enrollment files.

J. Privacy Act

Data that are protected in a Privacy Act System of Records (SOR) shall be released from the CMS in accordance with the Privacy Act (5 U.S.C. §552a) and the CMS data release policies and procedures. There appropriate Privacy Act disclosure exception for these releases is found in System No. 09-70-0536 (Medicare Beneficiary Database).
The parties agree and acknowledge that they are performing “covered functions” as that term is defined in the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Rule”) under the HIPAA at 45 C.F.R. § 164.501. The parties further agree that the use and disclosure of Protected Health Information between the parties pursuant to this Agreement is for payment as defined in the Privacy Rule. The Parties further agree that the Protected Health Information be used or disclosed pursuant to this Agreement is the minimum necessary to accomplish the intended purposes of this Agreement. The parties agree to abide by all requirements of the Privacy Rule with respect to Protected Health Information used or disclosed under the Agreement.

K. Restriction on Use of Data

All data and information provided by the Parties shall be used solely for the purposes outlined in Section II of the Recitals. If the ADAP wishes to use the data and information provided by the CMS under this Agreement for any purpose other than those outlined above, the ADAP shall make a written request to the CMS outlining the additional purposes for which it seeks to use the data. If the CMS determines that the ADAP’s request to use the data and information provided hereunder is acceptable, the CMS shall provide written approval to the ADAP of the additional purpose for use of the data.

The terms of this Section K. shall not apply to the ADAP with respect to data contained in any Monthly Input Files, excluding any Medicare data which are provided by CMS to the ADAP in any Response Files.

L. Penalties for Unapproved Use of Disclosure of Data

The ADAP acknowledges that criminal penalties under section 1106(a) of the Social Security Act [42 U.S.C. § 1306 (a)], including possible imprisonment, may apply with respect to any disclosure of data received from the CMS that is inconsistent with the purposes and terms of the Agreement. The ADAP acknowledges that criminal penalties under the Privacy Act [5 U.S.C., § 552a (I) (3)] may apply if it is determined that the ADAP, or any individual employed or affiliated therewith, knowingly and willfully obtained the data under false pretenses. The ADAP also acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if the ADAP, or any individual employed or affiliated therewith, has taken or converted to its own use date file(s), or received the file(s) knowing that (it) they were stolen or converted. The ADAP further acknowledges that civil and criminal penalties under HIPAA (PL 104-191) may apply if it is determined that a person wrongfully discloses protected health information/individually identifiable health information.

M. AIDS Drug Assistance Program Contacts

Administrative Contact: The ADAP designates the individual listed below as the contact person for administrative or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for the CMS for any administrative questions that may arise during the term of this Agreement. If the ADAP changes its administrative contact person, the ADAP shall notify the CMS in writing within thirty (30) working days of the transfer
and provide the information listed below for the new contact person.

- **Name:** (Insert Name)
- **Address:** (Insert mailing address)
- **Phone #:** (Insert Phone #)
- **Fax #:** (Insert Fax #)
- **E-mail:** (Insert E-mail address)

**Technical Contact:** The ADAP designates the individual listed below as the contact person for technical or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for CMS for any technical questions that may arise during the term of this Agreement. If the ADAP changes its technical contact person, the ADAP shall notify the CMS in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

- **Name:** (Insert Name)
- **Address:** (Insert mailing address)
- **Phone #:** (Insert Phone #)
- **Fax #:** (Insert Fax #)
- **E-mail:** (Insert E-mail address)

**N. CMS Contact**

**Administrative Contact:** The CMS designates the individual listed below as the contact for administrative or other implementation coordination issues under this Agreement. The individual shall be the point of contact for the ADAP for any administrative questions that may arise during the term of this Agreement. If CMS changes the administrative contact person(s), CMS shall notify the ADAP in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

- **Name:** William Decker
- **Phone #:** (410) 786-0125
- **Fax #:** (410) 786-7030
- **E-mail:** william.decker@cms.hhs.gov

- **Address:** Centers for Medicare and Medicaid Services
  Office of Financial Management
  Financial Services Group
  Division of Medicare Secondary Payer Policy and Operations
  Mail Stop: C3-14-16
  7500 Security Boulevard
  Baltimore, Maryland 21244-1850

**Technical Contact:** Upon implementation of this agreement through signature by both parties, CMS will designate a Coordination of Benefits Contractor (COBC) Electronic Data Interchange (EDI) Representative as the COBC contact for technical or other implementation coordination.
issues under this Agreement. The EDI Rep shall be the point of contact for the ADAP for any technical questions that may arise during the term of this Agreement. If CMS changes the technical contact, the COBC shall notify the ADAP within thirty (30) working days of the transfer and provide contact information for the new EDI Rep.

O. Miscellaneous

1. The Parties agree that their respective representatives, whose signatures appear below, have the authority to execute this Agreement and to bind each of the Parties, respectively, to every promise or covenant contained in this Agreement. The Effective Date of this Agreement shall be the last date of execution by the Parties.

2. No alteration, amendment, modification or other change to the Agreement shall be effective without the written consent of the affected Party or Parties. No waiver of this Agreement or of any of the promises, obligations, terms, or conditions contained herein shall be valid unless it is written and signed by the Party against whom the waiver is to be enforced. This applies only to alterations, amendments, modifications or other changes to information contained in this Agreement and not to the User Guide.

3. The Parties agree that this Agreement, together with the User Guide, includes all material representations, understandings, and promises of the Parties with respect to this Agreement. This Agreement shall be binding upon the Parties, their successors, and assigns.

4. In the interest of protecting confidentiality of ADAP-covered individual data, information received by the Parties hereto that does not result in a match relevant to this Agreement shall be destroyed within twelve (12) months following a Party's completion of the matching process. Each Party to this Agreement shall provide written confirmation to the other that all data and information that does not result in a match has been destroyed within that time frame if requested by either Party. The Parties further agree that if “hard media” (e.g., round reel tapes, cartridges, CDs, etc.) were used to exchange data, such media shall be destroyed within twelve (12) months of receipt.

5. The Parties may transmit the data required to be exchanged under this Agreement electronically, provided the Parties agree on a methodology and format within which to exchange such documentation as required by the User Guide, and the transmission is secure.

6. The ADAP shall provide a header and trailer for each file submitted using the data elements in the record layout as prescribed in the User Guide.

7. The ADAP agrees that it will inform its related entities to the extent necessary to pay prescription drug claims in accordance with the MMA provisions. The ADAP shall share the Medicare Part D entitlement information, identified as a result of this data exchange, with these entities for their use in paying prescription drug claims in accordance with the Medicare Part D provisions.

8. No fees are payable by either party with respect to this Agreement.
9. Except as specifically provided herein, the rights and/or obligations of either party to this Agreement may not be assigned without the other party's written consent. This agreement shall be binding upon and shall inure to the benefit of and be enforceable by the successors, legal representatives and permitted assigns of each party hereto.

10. If either party cannot release its respective file in a timely manner, it must notify the other party at least one week prior to the scheduled release of the file that the submission shall be late. A date as to when the file will be released shall be provided at that time.

11. The ADAP agrees to provide to the CMS a list of all its standard and TrOOP facilitation RxBINs and RxPCNs no later than ten (10) days prior to submission of the Initial Input File. The ADAP further agrees to update this list no more than thirty (30) days after receiving any new coding numbers.
P. SIGNATURES

IN WITNESS WHEREOF, the Parties have signed this Agreement on the date indicated below.

Centers for Medicare and Medicaid Services

By: GERALD WALTERS  
Director, Financial Services Group 
Office of Financial Management 
Duly Authorized Representative

(Insert ADAP Name)

By:  
(Insert ADAP Representative Name) 
(Insert Title)  
Duly Authorized Representative

V: 8/9/05(c); 7/27/07(d); 1/22/08(e); 7/12/10(f)
Implementation Questionnaire
For AIDS Drug Assistance Programs

Data Sharing Agreement
AIDS Drug
Assistance Program DSA Implementation Questionnaire

ADAP Name: _______________________________________

Date: _______________________________________

Please check all that apply:

I. ADAP Specific Information

☐  ADAP offers a network prescription drug benefit.

☐  ADAP offers a network prescription drug benefit and shall provide its RxBIN and/or RxPCN below. (If you have more than one RxBIN or PCN, please submit all of these numbers to the CMS in a separate attached Word document).

RxBIN ______________________
RxPCN _____________________

☐  ADAP offers a network prescription drug benefit and shall provide its TrOOP Specific RxBIN and RxPCN below. (If you have more than one TrOOP RxBIN or RxPCN, please submit all of these numbers to the CMS in a separate attached Word document).

TrOOP RxBIN ______________________
TrOOP RxPCN ______________________

II. Questions regarding how the ADAP will submit prescription drug coverage of its Program Enrollees:

☐  ADAP will satisfy its Data Sharing Agreement requirement to submit prescription drug coverage of its SPAP Enrollees using the Input file of the SPAP Data Sharing Agreement.

☐  ADAP contracts with a Pharmacy Benefit Manager (PBM) to pay prescription drug benefits in the pharmacy network. Please provide the name of the PBM ______________________.

☐  ADAP’s PBM, named above, has (1) signed a Data Sharing Agreement with CMS and (2) signed an agreement with the ADAP stating they will satisfy the Supplemental Drug Program’s Data Sharing Agreement requirement to submit prescription drug coverage of its Supplemental Drug Program Enrollees.
1) What is the purpose of the Veterans and the Ryan White CARE Act: FAQs and Resources?

Answer:

In December 2004, HRSA/HAB issued a policy notice entitled “Ryan White CARE Act and Veterans.” The policy notice was designed to clarify the provision of CARE Act services to veterans living with HIV who are also eligible for Department of Veterans Affairs (VA) health care benefits.

The policy was developed in response to reports that some CARE Act programs were simply directing all veterans to VA programs, as these programs struggled with waiting lists and managing limited resources. There were also cases cited where a VA would no longer serve a veteran living with HIV and refer the veteran to a local CARE Act grantee, who had to sort out payer of last resort issues. Working closely with the VA, HRSA/HAB developed the CARE Act and Veterans Policy Notice to clarify how to handle these situations. The HRSA/HAB policy notice is clear: CARE Act grantees may not deny services, including prescription drugs, to a veteran who is otherwise eligible for CARE Act services.

The following frequently asked questions (FAQs) seek to clarify specific questions the Ryan White CARE Act programs have raised about the policy and provide information about resources available to veterans in the VA health care system. In addition to this FAQ document, the Bureau has conducted a number of efforts to ensure that this critical policy is widely disseminated, understood, and implemented by CARE Act grantees, subgrantees and contractors. Individual grantee policies should be consistent with the HAB policy. HAB conducted a National Technical Assistance (TA) Call in June 2005 to help Ryan White CARE Act programs understand the policy and the challenges and lessons learned in navigating care for veterans with HIV.

For additional information about other VA benefits eligibility, including housing, education and training, vocational rehabilitation and employment benefits and services for homeless veterans check the VA’s World Wide Web pages (http://www.va.gov) or contact a VA benefits office at 1-800-827-1000. Each year the VA publishes and updates the “Federal Benefits for Veterans and Dependents” pamphlet.

COORDINATING CARE ACT AND VA SYSTEMS OF CARE

Headline: Ryan White CARE Act program coordinate health care benefits for veterans

2) How does a CARE Act program coordinate health care benefits for veterans?

Answer:

When a veteran with HIV comes to a CARE Act provider, one of the first things to do is determine and verify eligibility for CARE Act and other services. This helps ensure that the individual is provided the widest range of needed medical and support services. This intake may be performed by the grantee or another appropriate entity and may be a new or updated assessment. CARE Act grantees should inquire whether an individual is a veteran and whether the veteran is enrolled at the VA.
Grantees should be knowledgeable about the VA medical benefits package, which includes prescription drugs. A veteran may be missing out on important health care services if neither of you are familiar with the VA’s benefits. If transitioning from a CARE Act funded or other community-based medical provider to VA-based HIV care, enrolled veterans may experience wait times for initial appointments or other delays that can result in interruptions of medical or pharmaceutical care. CARE Act grantees should work with veteran clients to ensure that such gaps do not jeopardize the veteran’s HIV treatment. Similarly, VA health systems should work with clients to ensure that service gaps do not jeopardize the care of veterans who choose to leave the VA system.

The obligation to know the VA health care system reflects the CARE Act mandate to be the payer of last resort. The inherent obligation for CARE Act programs in fulfilling this mandate is to determine an individual’s eligibility for services from all sources to ensure that the individual is provided the widest range of needed primary medical and support services. Services that must be reimbursed by any private or public payers should be determined before CARE Act funds are used to pay for care. While veterans cannot be required to seek their care in the VA, CARE Act programs can provide a valuable service in making veterans aware of services available, eligibility and other procedures for getting VA care, and how best to help them navigate care systems to secure HIV care.

The December 2004 HRSA/HAB policy notice is clear: CARE Act grantees may not deny services, including prescription drugs, to a veteran who is otherwise eligible for CARE Act services.

3) In implementing the CARE Act payer of last resort mandate, can a CARE Act provider deny services to an HIV infected veteran?

Answer:

No. CARE Act grantees may not deny services, including prescription drugs, to a veteran who is otherwise eligible for CARE Act services. CARE Act grantees or subgrantees should refer eligible veterans to the VA for services, when appropriate and available. However, CARE Act grantees or subgrantees may not require eligible veterans to access VA care against their will.

The CARE Act obligation to serve as the payer of last resort is a hallmark of the legislation. In cases where the VA does not provide needed services, the CARE Act would fulfill its obligation as payer of last resort. In situations where the veteran does not wish to receive VA services that are otherwise available to that individual, the veteran is not required to obtain their services from the VA. CARE Act funded grantees may provide services although reimbursement from the VA is unlikely because the VA does not usually pay for medical care that veterans choose to obtain from other sources.

4) Why don’t veterans with HIV get their care through the VA?

Answer:

All enrolled veterans may choose to receive their care from the VA health care system. However, even if enrolled for VA health care, a veteran does not have to use the VA as their exclusive health care provider. Just like the CARE Act, the VA has limited resources and is funded each year by Congressional appropriations. The VA encourages veterans to retain any health care coverage they may already have.
5) **What are some reasons a veteran may choose to use their other sources of coverage for their routine care or as a supplement to their VA medical care benefits?**

**Answer:**

There may be multiple reasons a veteran might not seek care at the VA, or a specific service offered by the VA:

- There may be services the CARE Act or other payers provide that are not included in the VA medical benefit package. Veterans may be eligible for a variety of services from other payers. In some cases, these services may be preferable in addressing the veteran's care needs.

- Just as the CARE Act has limited resources and is funded each year by Congressional appropriations, VA health care is not an entitlement program, unlike Medicare or Medicaid. The VA encourages veterans to retain any health care coverage they may already have, including private health insurance or with federally funded coverage through the Department of Defense, Medicare, or Medicaid. They may choose to use these sources of coverage either as their primary source of care or as a supplement to their VA benefits.

- Veteran's access to VA care may vary by geographic location, given both the regional differences across the VA's system and variations in local operation of veteran's facilities.

- Not all VA facilities have an HIV program.

**CARE Act grantees can provide a valuable service in assisting veterans to establish care within the VA system by becoming familiar with enrollment procedures, eligibility requirements, and local VA contacts for coordination of HIV care. CARE Act grantees should become familiar with their local VA care system, especially those facilities with experienced HIV providers. The VA provides comprehensive direct care for veterans. In some cities, several VA facilities and clinics are available. A veteran may select any VA health care facility or clinic to serve as his or her primary treatment facility. HIV veterans living in communities with more than one VA facility or clinic may wish to select their site based on availability of HIV services in that facility.**

Some veterans have not enrolled or used a VA facility and may not know the VA's eligibility requirements. Only the VA, however, can determine whether a veteran is eligible for VA benefits. A veteran may be eligible for some but not all VA benefits, including health care, disability, vocational rehabilitation, and other services.

6) **Where should CARE Act programs start in coordinating with the VA on the delivery of services to veterans and State or local planning?**

**Answer:**

HIV/AIDS caseloads of individual VA facilities and the degree to which they are involved in care planning with other agencies vary considerably. Regardless, the VA encourages the development of local collaborations between VA HIV providers and CARE Act grantees. Each VA facility has a designated HIV/AIDS coordinator.

To find a VA in your area, see the VA's web site (http://www1.va.gov/health_benefits) and make sure that the veteran is actually enrolled in the VA system. CARE Act grantees may obtain the name and contact information for their local VA facility HIV/AIDS coordinator from the VA's National Prevention Coordinator, Ms. Donna Wells, BS, RRT (donna.wells@hq.med.va.gov or call (202) 273-8205).
HIV/AIDS coordinators can assist CARE Act grantees to identify key staff and HIV clinicians who deliver HIV care and identify those who can represent the VA facility in HIV care planning and coordination.

7) How can the CARE Act programs obtain data about HIV infected individuals served in the VA health care system in our community or State?

Answer:

The VA made available de-identified, facility specific data on HIV care delivered by the VA. Check their web site: http://www.publichealth.va.gov/hrsa/data.htm. Since the VA system is not organized along State or municipal boundaries, those breakdowns are not always available.

The link provides an explanation of how the data are presented and data tables by VA facility. There is also a chart included of VA facility zip code so CARE Act grantees can best identify their local VA facilities.

The VA made every attempt to provide the data requested and to array the data in the manner proposed by HRSA/HAB. Also, the data was provided in an aggregate format to protect the privacy of veterans, as specified in the VA statute.

CONTRACTING FOR VA AND CARE ACT SERVICES

8) Can CARE Act programs and the VA system contract with each other?

Answer:

Yes. Individual VA facilities or any of the 21 regional Veterans Integrated Service Networks (VISNs) can enter into contracts with other agencies or groups to provide care to veterans. Usually, this occurs when a specific service is not available in the VA system or when providing the service through a contract is more economical for the VA. For clinical services, the VA must identify a need, develop a “scope of work,” and then obtain bids for the cost of providing the services. In many cases, competitive bidding may be required. These arrangements typically involve the Chief of Staff’s office and the local VA Contracting Office.

Alternatively, VA facilities may provide services to other agencies or entities through a type of contract called a “sharing agreement.” VAs may contract to provide a range of services to non-veterans through sharing agreements with academic affiliates, other hospitals, or community agencies.

CARE Act providers may enter into contracts with the VA to provide services to HIV-infected veterans eligible for VA services. For example, a VA facility may not have a provider with sufficient HIV expertise to treat veterans. A local CARE Act-funded community-based provider would receive funds under the contract to ensure capacity to provide care to eligible veterans.

ELIGIBILITY FOR VA HEALTH CARE BENEFITS

9) What services can an enrolled veteran receive from the VA?

Answer:

VA medical benefits for enrolled veterans include a wide range of inpatient and outpatient services, including primary care, specialty care, substance abuse treatment, psychiatric and mental health care, pharmaceuticals, diagnostic tests, and social work services. Dental services are available but under very specific guidelines that vary significantly from eligibility requirements for medical care. Travel assistance may be available through VA facilities or local Veterans Service Organizations (VSOs). Each VA facility has a patient travel service that can help with details.
The VA Web site publishes an annual guide summarizing health care benefits available from the VA and related eligibility criteria. See the VA web site (http://www.va.gov/healtheligibility/home/hecmain.asp) or call the VA's Health Benefits Service Center toll free number (1-877-222-VETS (8387)) to receive copies of these documents. Women veterans are eligible for all medical services and necessary obstetric and gynecologic care, plus many VAs have specific clinics for women.

Many VA facilities have experienced HIV medical providers and serve large numbers of HIV infected veterans. Most HIV services are provided in the infectious disease programs of VA facilities and clinics. Many VA facilities participate in clinical trials, as well as provide other services needed by HIV infected patients.

Some VA facilities, however, do not have infectious disease specialists or experienced HIV providers on staff, in which case VAs may contract for these specialty services or refer veterans to other nearby VA facilities. CARE Act providers, as mentioned earlier, should become familiar with the VA facilities in their local areas and the HIV specialty care available.

Many veteran facilities and clinics provide an array of HIV prevention services. Prevention services are provided to HIV infected veterans as part of their clinical management. Veterans have cost free access to male and female condoms through the VA formulary. Substance use treatment is part of a standard VA benefit for enrolled veterans. Specific types of programs and services may vary by facility. Some VA facilities have their own opiate-replacement (methadone) therapy programs. Others may refer patients to community-based programs. Like other health care providers, the VA uses outpatient based treatment programs whenever possible.

10) What are the eligibility criteria for VA health care benefits?

Answer:

Eligibility for VA health care is based on several variables that may impact the final determination of the medical services that veterans qualify. Eligibility for most veterans health care veterans is based on active military service in the Army, Navy, Air Force, Marines, or Coast Guard (or Merchant Marines during World War II), and other criteria. VA health care benefits are not just for those who served in combat or have a service-connected injury or medical condition. More detailed information is in the HRSA/HAB policy notice and the VA's Web site: http://www.va.gov/healtheligibility/eligibility/enrollment_priority_groups.asp.

11) How can veterans get information about VA health benefits and apply for them?

Answer:

Veterans may obtain an application for VA health benefits and instructions for completing the application at: https://www.1010ez.med.va.gov/sec/vha/1010ez/. Veterans can obtain enrollment assistance by calling the VA's Health Benefits Service Center, Monday through Friday between the hours of 8:00 AM and 8:00 PM (Eastern Time) at 1-877-VETS.

Veterans can also obtain additional assistance by contacting the local VA health care facility (to see a list of local health care facility enrollment offices at: http://www1.va.gov/directory/guide/home.asp?isFlash=1 or by calling their State or county Veterans Service Officer (VSO). Contact the VSO on the web site (http://www1.va.gov/VSO/index.cfm?template=search) by looking in the blue pages of the phone book under “United States Offices,” then look for “Veterans Affairs.” There are several other ways a veteran may apply for VA health benefits. They can apply in person at any VA medical center or clinic. They also can enroll by mailing or faxing their completed Form 1010EZ to the Medical Center or Clinic of their choice. To find a VA medical center or clinic in your community use the facility locator: http://www1.va.gov/directory/guide/home.asp?isFlash=1. VA facilities are listed in the federal government sec-
12) Can HIV-infected veterans receive their care at the VA?

Answer:

Yes. The VA serves all veterans and has a commitment to provide high quality of care to all of the veterans they treat, including HIV-infected veterans, regardless of when they were infected and diagnosed. If a veteran does not feel welcome at a VA, the VA will address the issue.

13) How is HIV clinical quality assessed in the VA health care system?

Answer:

The VA's quality assessment and improvement program measures a wide range of quality indicators for clinical care. These include many clinical services important for HIV patients, such as screening for substance use and mental health problems, vaccinations and other prevention interventions, and control of co-morbid conditions such as diabetes and hyperlipidemia.

Specifically related to treatment of veterans with HIV, the VA's Health Services Research and Development program developed in 1998 a HIV/AIDS Quality Enhancement Research Initiative (HIV-QUERI) group. HIV-QUERI's mission is to make evidence-based HIV care more accessible, optimize the application of evidence-based HIV therapies, and improve the delivery of collaborative and comprehensive treatment of co-morbid conditions in order to ensure better health for veterans who live with HIV. Data from HIV-QUERI may be useful in regional planning efforts. For more information regarding HIV-QUERI, contact Ms. Joanna Bone, Administrative Coordinator, HIV-QUERI, Health Services Research and Development Service, Telephone: 858-552-8585 ext. 5954 or e-mail Joanna.Bone@med.va.gov.

14) Can the VA fill a veteran's prescription from a non-VA provider? How do veterans obtain medication refills?

Answer:

The VA will provide medications prescribed by VA providers in conjunction with VA medical care, if covered under their approved formulary. However, the VA will not simply fill or re-write prescriptions prescribed by a non-VA clinician. Because of the risks inherent in medication management, a VA provider must manage the veteran's health care or “co-manage” with a non-VA provider. If the veteran sees a non-VA provider and wants to have prescriptions filled by VA, all of the following criteria must be met:

• The veteran must be enrolled to receive VA health care

• The veteran needs to have an assigned primary care provider

• It is the veteran's responsibility to provide his or her VA health care provider with his or her medical records from the non-VA provider

• The VA health care provider has to agree with the medication prescribed by the veteran's non-VA provider.

Like most large health care providers, the VA employs a highly automated mail-out system for filling and re-filling most prescriptions. These systems are often confusing for some clients. Medication refills must be requested by mailing the refill notice provided to the veteran at the time of the original fill. The order will be processed through the VA pharmacy mail-out program. Routine refills cannot be processed at the pharmacy windows (unless there are special circumstances).
VA HEALTH CARE AND CO-PAYMENTS

15) Must veterans enrolled in VA health care services share the cost of care through co-payments?

Answer:

While many veterans qualify for enrollment and cost-free health care services based on a compensable service-connected condition or other qualifying factor, most veterans are asked to complete a financial assessment or “Means Test” as part of their enrollment application process.

Co-payments for outpatient medical care and pharmaceuticals may be required from veterans in some VA priority groups, primarily those without service connected disabilities and with higher income levels. Those veterans who choose not to complete the financial assessment must agree to pay required co-payments to become eligible for VA health care services.

A veteran may have to agree to pay some co-payments. Co-payments are charged for inpatient, outpatient, outpatient prescriptions, and long-term care. The VA does not require a monthly premium to use VA health care.

There are three options available to veterans who cannot afford co-payments: 1) request a waiver for making the payments; 2) request a hardship determination so that co-pays will not be charged in the future (this is, in effect, is a request for a change in Priority Group assignment); or 3) request a compromise, such as partial payment.

For information on enrollment in VA’s health care system including co-payments and both the Means Test thresholds and geographically based means testing see http://www1.va.gov/healtheligibility/costs/costs.asp.