

Ryan White Requirements and the LIHP - Frequently Asked Questions (FAQs) #3

Questions and Requests from Teleconference on August 22, 2011 with California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA), California Department of Health Care Services (DHCS), Low Income Health Program (LIHP) staff, California Ryan White (RW) Part B contractors, local LIHP administrators, and interested stakeholders.

SET #1: Issues most specific to OA.

1. Will OA convene a RW Part A grantee conference call?

Because OA's areas of responsibility and expertise are limited to RW Part B programs, OA will not coordinate conference calls for other RW Parts (A, C, and D) but will gladly participate if any are organized.

2. Must RW Part B contractors immediately start screening clients for LIHP?

OA and the Health Resources and Services Administration (HRSA) recognize that there are significant continuity of care, quality of care, and fiscal issues associated with the institution of LIHP and resultant RW payer of last resort considerations. Thus, OA has notified RW Part B contractors of the need to immediately begin developing a plan for incorporating the screening of clients for LIHP into their client enrollment processes. The plan needs to consider screening new clients upon initial application and current clients when they are scheduled for re-enrollment. Once the plan is developed, it must then be implemented according to the plan. (Please note that OA clarified any potential misunderstanding of the intent of this guidance that may result from paragraph 2, sentence 3, in the August 18, 2011 letter. Again, the requirement is to start planning not to immediately start enrolling unless it is feasible to do so with no loss of care continuity and quality.) Further guidance on planning in the ten LIHP "legacy" counties is anticipated to be provided on or shortly after September 14, 2011.

3. How will LIHP screening in the AIDS Drug Assistance Program (ADAP) be operationalized?

CDPH is in the early stages of developing our plan for ADAP and thinking through the challenges for clients who receive RW-financed medical care in a variety of

settings. For example, if the health care provider is already a LIHP provider, screening for LIHP eligibility in ADAP is not likely to result in a disruption to their health care. There could be specific pharmacy and drug formulary details that may vary between the two programs which will need to be considered to ensure continuity of care for these clients. For clients seen by health care providers who are not LIHP providers, delayed ADAP screening will be explained in the guidance on planning in the ten LIHP “legacy” counties that was provided on or shortly after September 14, 2011. Developing planning guidance with the goals of adhering to our RW grant requirements and maximizing continuity and quality of care and treatment will be a major focus for OA in the coming weeks.

4. Will RW Part B contractors have to start evaluating client eligibility bi-annually (every six months)?

OA is *not* requiring bi-annual screening of RW Part B clients at this time. However, HRSA requires bi-annual eligibility certification of all clients receiving RW services. See link to eligibility certification requirements references in the following documents which can be found at the following website:

<http://www.cdph.ca.gov/programs/aids/Pages/OARyanWhiteDHCSLowIncomeHealthProgram.aspx>

- 1) [HIV/AIDS Bureau, Division of Service Systems, Universal Monitoring Standards \(Section B: Eligibility Determination/ Screening\)](#).
- 2) [HIV/AIDS Bureau, Division of Service Systems, FAQs \(Question 36\)](#).

In the future, OA will be requiring all RW Part B contractors to verify eligibility twice a year for all clients. More guidance on this will be forthcoming.

5. Is the requirement for bi-annual (every six months) certification eligibility client specific or county specific?

Once implemented by OA, bi-annual re-certification of eligibility will be required for each client. Typically, re-certifications are conducted on a rolling basis according to birth date and not at a single point in time for all clients.

6. Will OA provide RW contractors with a sample tool for screening for LIHP eligibility?

OA will consider the feasibility of developing and distributing a screening tool.

7. Will OA provide the LIHP county administrators with a contact list of RW Part B contractors?

Yes, we have provided this information: [Local Ryan White Part B HIV Care Program \(HCP\) Contacts \(PDF\)](#)

8. If a LIHP county establishes an enrollment cap for services and implements a waiting list, is a LIHP-eligible client on the waiting list eligible to receive RW services?

Yes. RW services can be provided to eligible clients until they are enrolled into another third-party payer such as LIHP and cleared from any waiting list.

9. Has there been a discussion to put a “tickler” or reminder notification into AIDS Regional Information and Evaluation System (ARIES) to ensure timely recertification?

We had not thought about this, but OA will consider the feasibility of modifying ARIES to support timely recertification for providers.

10. Can new ADAP enrollment workers (EW) get extra training on all these issues?

Yes, OA will set up additional calls for EWs in the LIHP legacy counties first, then in the non-legacy counties.

SET #2: Issues most specific to LIHP or DHCS.

1. Can DHCS provide a current list of LIHP county contacts?

This information can be found at the following links: [Primary Program Contacts for the Local Low Income Health Program \(LIHP\)](#). Please note that the contact information should not be released to RW clients. The contact information for general information regarding the individual county LIHPs will be posted on the LIHP Webpage soon.

2. Can DHCS clarify on this list the counties that are part of County Medical Services Program (CMSP)?

CMSP counties are: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

3. Are the dates listed in the Projected LIHP Implementation Dates document accurate? If not, when will the approved implementation dates for the individual county LIHPs be available?

The dates in the Projected LIHP Implementation Dates document that was posted on the LIHP Webpage have been updated. The approved effective dates for the ten legacy county LIHPs is July 1, 2011. The execution of the contracts between DHCS and the counties will be effective no later than September 30, 2011. Each of these counties may begin enrollment of individuals into their new LIHPs at risk, prior to full execution of their contracts. The implementation dates of LIHPs in the rest of the counties are constantly fluctuating due to the authorization process which requires the time that is necessary for LIHP staff to work with the local LIHP to achieve all requirements for approval of the program and the contract. The Centers for Medicare and Medicaid Services (CMS) requires a 60-day contract review and preliminary approval process. When that process is complete, the local LIHPs have a local county approval process that can take anywhere from a few days (with a County Board of Supervisors [CBOS]delegation) to 60 days, depending on the CBOS schedule to execute the contract. Once the contract is executed locally, it is sent to DHCS for final execution, then sent to CMS for final approval. Then, the LIHP can implement. DHCS will immediately inform OA as the local LIHP implementation dates are updated through these processes.

4. How are the local LIHPs determining the availability and adequacy of HIV care within their provider networks?

DHCS has consulted with several counties and will provide this information when available.

5. What does the pharmacy benefit look like in the LIHP counties – will it include all the drugs on the ADAP formulary?

LIHPs are required to construct their drug formularies according to Medicaid regulations for managed care plans. They are also required by their contract with DHCS to include both brand and generic drugs in their formularies and to consider the drug needs of their enrollees living with HIV to ensure continuity of care. The local LIHPs will be designing their drug formularies based on the ADAP formulary and the Medi-Cal Managed Care drug formularies. Regardless of whether a drug is on or not on the local LIHP drug formulary, if the drug is determined medically necessary for the enrollee, it must be provided by the local LIHP.

6. Could the prior authorization requirement in the local LIHP drug formularies result in disruption of access for the RW/LIHP enrollees to the types of drugs that they are currently receiving which are on the ADAP formulary?

DHCS does not anticipate that the RW/LIHP enrollees will experience disruption in their drug prescriptions which they currently receive through their RW providers as a result of the prior authorization requirements in the local LIHPs. The managed care step therapy process and other types of existing HIV drug therapies that many of the existing RW clients are receiving may be continued under LIHP through the prior authorization process. Through the care coordination process in the local LIHPs, the primary care providers in the local LIHPs will communicate with the enrollee's RW providers to coordinate the continuation of the medical services and drug therapies and regimens associated with the enrollee's HIV diagnosis.

7. Will DHCS work with OA to ensure that their expertise in the ADAP formulary and other HIV drug therapies is taken into consideration to avoid all unnecessary prior authorization requirements that may result in disruption of access to the types of drugs that are currently on the ADAP formulary?

LIHP is a voluntary, county program that is financed entirely by county and federal Medicaid funding. Therefore, DHCS and OA cannot mandate the prior authorization requirements for the drug formularies and medical services in the local LIHPs. CMS requires that the local LIHPs be structured as managed care delivery systems, which are required to utilize prior authorization processes in their systems. Both CMS and DHCS review and approve the prior authorization processes and procedures for the local LIHPs. Through this review process, DHCS medical professionals will consult with OA experts when necessary to determine the appropriateness of these processes and procedures as they relate to HIV drugs.

SET #3: Cross-Cutting Issues

1. What sort of documentation will be required to show that a RW client is currently on a LIHP waiting list?

This will need to be determined on a county by county basis based upon any waiting list procedures established by the local LIHP program. OA also plans to work with DHCS to provide additional guidance on this issue in the future.

2. Is language required in the contract between the local LIHP and RW providers to receive reimbursement for services provided to RW clients who are eligible for a retroactive coverage period under LIHP?

The reimbursement process between the county LIHP and RW provider should be detailed in the contract between the two parties. The reimbursement process should include the allowable services, timeframes, procedures, and reimbursement rates for allowable services provided to LIHP enrollees by RW providers during a retroactive coverage period under the LIHP.

3. What is the expectation from HRSA that RW providers will back-bill LIHP for services provided to LIHP-eligible clients?

Please see the letter from HRSA dated August 9, 2011 ([HRSA letter August 9, 2011](#)). In Issue #1, HRSA recognizes that “any period of retroactivity will be defined by the county. If the county’s LIHP policy for all enrolled includes coverage that is retroactive..., then any RW services... will need to be back-billed.” At this time, among the ten “legacy” counties, only San Diego (30 days) and Orange (90 days) Counties have a retroactive eligibility component.

In Issue #3, with respect to services provided by RW providers that do not have a LIHP contract but are developing one, HRSA “encourages careful consideration of ... critical access issue in the drafting of provider contracts.” HRSA further states that “LIHP and RW grantees should draft... contract provisions to permit back-billing for uncompensated services provided by RW providers while contracts are being established so as to mitigate disruption to patient care.” CDPH and DHCS are continuing to work together and with HRSA and CMS to ensure full understanding of this guidance and to advocate for the most flexible interpretation possible so as to allow for maximum continuity and quality of care and minimum fiscal impact..

4. If there is a temporary barrier to accessing drugs through LIHP that are on the ADAP formulary, can ADAP provide these drugs to previous clients?

OA and DHCS will work together to try to ensure that there will not be barriers to access during the transition of clients from ADAP to LIHP.