Austin TGA Administrative Agent Report
To HIV Planning Council
July 2018

PART A & MAI GRANTS ADMINISTRATION/ MANAGEMENT UPDATE

1. The Austin TGA's Part A Project Officer, Tempestt Woodard, has left HAB/HRSA for another career opportunity. A new Part A Project Officer, Michael Carrigan, has been assigned to Austin, but will not start until August 20.

2. Mark Peppler, Chief of the Southern Services Branch of the Division of Metropolitan HIV/AIDS Programs (DMHAP) at the HAB/HRSA, still plans to travel to Austin as part of the Part A Site Visit August 28-31 along with the new Project Officer and two HRSA consultants. The Quality Management (QM) portion of the Site Visit will be conducted remotely, with the AA sending documents electronically to HAB/HRSA and review taking place in another location, followed by a conference call. Further details are not known at this time. Other preparations for the Site Visit continue to ramp up as it grows ever closer. **The HAB/HRSA Site Visit Team plans to meet with the HIV Planning Council Executive Committee in special session and attend the Council Business Meeting on August 28, 2018.**

3. AA and Planning Council staff are busily at work on preparing their respective portions of the Part A FY19 Application, due September 21, 2018. One significant change is the detail that must be provided regarding the TGA's MAI Program. With potential increased scrutiny from HAB/HRSA, the TGA's MAI Program may require future adjustments.

4. Final FY18 Part A contract amendments with subrecipients are in process, with an aggressive amendment timeline calling for execution by August 23. After these amendments, Part A contracts will reflect actual budgets and performance measure goals that match final awards, excluding any future carryover or reallocations. The AA is able to process all final subrecipient awards without City Council action. However, some contracts are close to the maximum amount allowable under law, and six FY18/FY19 "not-to-exceed" contract increases are on the City Council agenda for August 23. If approved as proposed, the AA anticipates only a slim chance of needing to return to Council for further contract approvals for FY18 or FY19.

5. The Part A Final Financial Report (FFR) was submitted on the due date, July 30, and includes the proposed carryover amount. As soon as the report is approved, the AA will begin work on the Carryover Request to submit to HAB/HRSA.

6. HAB/HRSA has issued a new Policy Clarification Notice (PCN 18-01) on the use of RWHAP Funds for Health Care Coverage Premium and Cost Sharing Assistance. A copy of the new

PCN is attached. AA staff are reviewing the PCN to determine if it will require any changes in the Austin TGA.

7. A service provider meeting was held Friday, July 20 at the City's Learning and Resource Center, with all seven Part A subrecipients represented.

8. The AA has begun preparations for the Annual Subrecipient Monitoring, which will take place approximately the first three weeks of November, 2018.

9. The contract with the Texas Department of State Health Services (DSHS) to pay for ADAP prescriptions already dispensed at the end of the Part A grant year is expiring, and a replacement contract is being negotiated. This contract provides the ability for the AA to expend unspent Part A dollars at the end of the grant year should such funds exceed allowable carryover. Other than typical contracting delays, no problems are anticipated with the renewal.

PART A & MAI FISCAL UPDATE

10. FY18 Expenditure Summary March 2018-May 2018; Percent of year elapsed: 25%

CATEGORY	Budgeted Amount	Expended Amount	Percent Expended
DIRECT SERVICES	$4,182,620	898,115	21%
ADMINISTRATION (HRAU & Planning Council Support)	$492,073	54,602	9%
QUALITY MANAGEMENT	$246,036	31,207	13%
TOTAL	**4,920,729**	**$983,924**	**20%**

Expenditures by service category are provided monthly to the Allocations Committee.

QUALITY MANAGEMENT UPDATE

11. Staff attended a Fast Track Cities/Getting to Zero planning meeting, and will be participating in Consortium Workgroups in the following areas: Rapid Linkage to Care, Retention, Reengagement, and Viral Suppression.

12. CQM staff are providing assistance during the TGA's transition from Outreach Services to Early Intervention Services.

13. An all-day Nonviolent Crisis Intervention training was held on July 25th, for HIV services provider staff to learn strategies and techniques that can deescalate potentially dangerous situations.

14. The QM Coordinator applied to join The Texas HIV Syndicate, a collaboration of leaders from across the state, working together to share and generate insights into a variety of HIV-related issues.

15. CQM staff are working with the Texas Department of State Health Services (DSHS) ARIES data team and a data analyst at the Outpatient Ambulatory Health Services (OAHS) provider, to prepare for producing quarterly outcomes reports on selected HIV/AIDS Bureau (HAB) clinical performance measures.

16. Staff are reviewing numerous data sets sent by DSHS for use in the FY 2019 Part A Grant Application.

17. Monitoring tools, which contain some quality assurance elements, are being checked for possible revision prior to the annual site visit monitoring that will take place this fall.

18. The DSHS finalized standards of care for Oral Health Services and Medical Transportation are being reviewed by providers, with comments submitted prior to the next Comprehensive Planning Committee meeting.

19. The Data Manager has completed several trainings on how HIV service providers can upload eligibility verification documents in ARIES, a new feature in ARIES that will reduce the administrative burden on service providers and clients.

20. Feedback on annual CQM Plans, outcomes reports, and other quality improvement issues will be discussed at CQM site visit meetings with providers in August.

CLIENT COMPLAINTS

21. There was one complaint on behalf of a client that was received directly by the Administrative Agency. The QM Coordinator has contacted the agency named in the complaint.

OTHER

22. Interviews are underway for the HRAU Manager vacancy.

23. Austin Public Health has instituted a new goal of having all social service contracts and renewals, including grants, in place by the first day of the program period, even if funding cannot be encumbered when the contract/amendment is executed. This is intended to protect both APH

and subrecipients, providing a legal vehicle under which services can continue to be delivered while funding is encumbered. Encumbrance of funds is a much quicker process than contract execution or amendment. This change has significantly moved up the tasks for contractors and staff into an already exceptionally busy season for HRAU.

24. HRAU received Austin Public Health's final Part C Notice of Award, which for FY18 provides essentially level funding. The unit is continuing to work on the Part C Non-Competitive Continuation application for FY19. In a Non-Competitive year, little funding change is expected. The application for FY20 will be the Competitive year for the three-year Part C cycle.

25. The City of Austin General Fund Request for Applications (RFA) will be launched on August 2. Information and forms will be posted on the Austin Public Health website. The HIV Resources Administration Unit (HRAU) will share the URL with Planning Council staff should members wish to review the solicitation documents. Approximately $630,000 on an annual basis is being competed; initial contract terms will be 42 months (3 ½ years).

26. HRAU Activity Timeline:
    - August 2: GF RFA Issued
    - August 15:Draft FY17 Carryover Request Written
    - August 16: Part A Final Award Amendments to COA Purchasing
    - August 21: Program Terms & Program Submission Report Due
    - August 24: Part C Application Due
    - August 23-24: DSHS Part B Meeting
    - August 28-31: Part A HRSA Site Visit
    - September 3: Labor Day Holiday
    - September 5-8: US Conference on AIDS
    - September 10: GF RFA Applications Due to HRAU
    - September 11?: HOPWA Contract Council Date
    - September 21: Part A Application Due
    - September 28: Part A TGA/EMA Quarterly Meeting, Dallas
    - October 8 (week of): GF RFA Evaluator Meetings
    - October 15: Begin Part C Contract Amendment Process for FY19
    - October 15-31: GF RFA Negotiations
    - November 1: GF RFA Recommendations to APH Management
    - November 11: Veterans Day Holiday
    - November 22-23: Thanksgiving Holiday
    - November 27-29: Texas Annual HIV/STD Conference
    - November 29 :GF RFA Contracts Council Date
    - December 11-14 – Ryan White National Conference
    - December 24-25: Christmas Holiday
    - December 31: End of Part C Grant Year

Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Policy Clarification Notice (PCN) #18-01
Replaces PCNs #07-05, #13-05, and #13-06
Relates to PCNs #13-01, #13-04, #14-01, and #16-02

Scope of Coverage

Ryan White HIV/AIDS Program Parts A, B (including the AIDS Drug Assistance Program [ADAP]), C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This PCN streamlines the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HRSA HAB) policy regarding the use of Ryan White HIV/AIDS Program (RWHAP) funds for premium and cost sharing assistance for the purchase and maintenance of private health insurance, Medicaid, and Medicare coverage. This updated PCN simplifies and replaces the following three notices: 07-05 *Use of Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance*; 13-05 *Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance*; and 13-06 *Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid*.

Background

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that 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] Recipients must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. RWHAP recipients and their subrecipients are expected to vigorously pursue enrollment into health care coverage for which their clients may

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

be eligible (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, state-funded HIV programs, employer-sponsored health insurance coverage, and/or other private health insurance) in order to maximize finite RWHAP grant resources.

The RWHAP, as the payor of last resort will continue to fund RWHAP services not covered, or partially covered, by public or private health care coverage. RWHAP recipients and subrecipients should consider assisting individual clients by paying for premiums and/or cost sharing, if cost effective.

General Guidance and Expectations

Using RWHAP Part A, Part B, ADAP, Part C, and Part D Funds to Pay for Health Care Coverage

According to RWHAP statute, funds awarded under RWHAP Parts A, B, and C may be used to support the HRSA RWHAP core medical service "Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals," regardless of the kind of health care coverage (public or private), in accordance with Section 2615 of the Public Health Service Act (Continuum of Health Insurance Coverage) and HRSA HAB PCN 16-02 *Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds*."[2]

According to statute, funds awarded under RWHAP ADAP may be used to cover costs associated with health care coverage, including co-payments, deductibles, and premiums, in accordance with Section 2616 of the Public Health Service Act (Provision of Treatments) and HRSA HAB PCN 16-02, regardless of the kind of health care coverage (public or private).

RWHAP Part D recipients may use funds to support the HRSA RWHAP core medical service "Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals," in accordance with HRSA HAB PCN 16-02.

All RWHAP recipients must determine how to operationalize their health care coverage premium and cost sharing assistance programs and demonstrate that:

1. Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV,[3] as well as appropriate HIV outpatient/ambulatory health services; and

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[2] *See* Section 2604(c)(3)(F), Section 2612(c)(3)(F), and Section 2651(c)(3)(F) of the Public Health Service Act.

[3] https://aidsinfo.nih.gov/guidelines

2. The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications *and* other appropriate HIV outpatient/ambulatory health services (RWHAP Part A, RWHAP Part B, RWHAP Part C, and RWHAP Part D). RWHAP ADAP must determine the cost of paying for the health care coverage is cost-effective in the aggregate *versus paying for the full cost for medications.*

RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and cost sharing.

RWHAP recipients must be able, upon request, to demonstrate the methodologies applied for determining compliance with these two requirements. As with other allowable costs, recipients are responsible for accounting and reporting on funds used for this purpose.

Guidance and Expectations for Specific Types of Health Care Coverage

Private Health Insurance

Private health insurance consists of any health care coverage that can be purchased by an individual or an employer. This includes private health insurance associated with employment (e.g., employer-sponsored or continuation of health care coverage such as Consolidated Omnibus Budget Reconciliation Act (COBRA)) and private health insurance otherwise available for purchase by an individual or family. Private health insurance plans must, at a minimum, provide comprehensive primary health care services, deemed adequate by the state. RWHAP funds may be used to cover the cost of private health insurance premiums and cost sharing (including deductibles, copayments, and coinsurance) to assist eligible low-income clients in maintaining private health insurance or receiving medical benefits under a health insurance or benefits program, including high-risk pools. However, RWHAP funds must not be used to pay for any administrative costs outside of the premium payment of health plans or high-risk pools. It is particularly important that all sources of premium and cost sharing assistance[4] are included in the cost effectiveness calculation. RWHAP recipients must vigorously pursue these other

[4] Advance premium tax credits and other federal or state cost sharing reductions may be available and need to be considered in cost-effectiveness determinations.

sources of premium and cost sharing assistance to ensure RWHAP remains the payor of last resort.

Medicaid

Medicaid provides health care coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

In some states, Medicaid-eligible clients may incur premium expenses and/or cost sharing. RWHAP funds may be used to pay the cost of Medicaid premiums, deductibles, and copayments consistent with federal regulations and RWHAP policy.

Some states may use Medicaid funds to provide Medicaid-equivalent coverage through the purchase of private health insurance. In instances where the private health insurance does not meet Medicaid standards, the Medicaid program must provide the wrap-around coverage and cost sharing assistance necessary to make the coverage Medicaid-equivalent. RWHAP funds must 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.

Recipients and subrecipients are strongly encouraged to work with their state Medicaid program to coordinate payment of premiums and cost sharing for clients, where permitted.

Medicare

Medicare is health care coverage for people who are age 65 and older and certain other populations affected by disability funded and administered by the Centers for Medicare & Medicaid Services (CMS). There are four parts:

- Medicare Part A (hospital insurance) covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, and home health care;
- Medicare Part B (medical insurance) covers doctor and other health care providers' services, outpatient care, durable medical equipment, home health care, and some preventive services;
- Medicare Part C (Medicare Advantage Plans) provides Medicare Part A and B benefits, and may include prescription drug coverage (Part D); and
- Medicare Part D Medicare Prescription Drug Coverage - covers prescription drugs.[5]

[5] See What Medicare Covers: https://www.medicare.gov/what-medicare-covers/index.html

RWHAP funds may be used to pay for Medicare premiums and cost sharing associated with Medicare Parts B, C, and D coverage, when doing so is determined to be cost effective in the aggregate and includes coverage for both outpatient/ambulatory health services and prescription drug coverage that includes at least one drug in each class of core antiretroviral therapeutics, as described above.

To meet this requirement, RWHAP Part A, B, C, and D recipients may use funds to pay for Medicare Part B (outpatient/ambulatory health services) premiums and cost sharing, but must also pay for the Medicare Part D (medication) premiums and cost sharing. RWHAP Part A, B, C, and D recipients may also use funds to pay for Medicare Part C premiums and cost sharing assistance, when the plan covers both outpatient ambulatory health services and at least one medication in each drug class of core antiretrovirals. If the Medicare Part C plan does not cover at least one medication in each drug class of core antiretrovirals, the RWHAP Parts A, B, C, and D recipients, must also pay for Medicare Part D premiums and cost sharing to meet the RWHAP requirement for health care coverage.

RWHAP Parts A, B, C, and D may not pay premiums for Medicare Part D alone; however, *RWHAP ADAP funds may be used to pay Medicare Part D premiums and cost sharing assistance alone, when it is cost-effective to do so versus paying for the full cost of medications.* RWHAP funds must not be used to pay for premiums or cost sharing assistance for Medicare Part A, as inpatient care is not a RWHAP allowable cost (see Table 1).

Table 1. Medicare Costs Allowable in the RWHAP

Medicare Part	***RWHAP Funds***
Medicare Part A	Must not be used by any RWHAP recipient to pay premiums or cost sharing.
Medicare Part B	May be used by all RWHAP recipients to pay premiums and/or cost sharing in conjunction with paying for Medicare Part D premiums or cost sharing.
Medicare Part C	May be used by all RWHAP recipients to pay premiums and/or cost sharing when the Medicare Part C plan includes prescription drug coverage; or in conjunction with paying for Medicare Part D premiums and cost sharing for plans that do not include prescription drug coverage.
Medicare Part D	May be used by RWHAP Part A, B, C, and D recipients to pay premiums or cost sharing in conjunction with paying Medicare Part B or Medicare Part C premiums or cost sharing

Medicare Part	*RWHAP Funds*
Medicare Part D *(continued)*	May be used by RWHAP ADAP recipients to pay Medicare Part D premiums and cost sharing when cost effective versus paying for the full cost of medications.

RWHAP funds must not be used to reimburse Medicare Part B premiums paid by clients because cash and cash-equivalent payments to RWHAP clients are prohibited. However, state or local government entities or other organizations can enter into a group-billing arrangement with CMS to pay Medicare Part B premiums directly to CMS (42 C.F.R. section 408.60).

RWHAP recipients should refer to HRSA HAB PCN 16-02 for additional information regarding paying health insurance premiums and cost sharing assistance.

Conclusion

RWHAP funds may be used to help clients purchase and maintain health care coverage, in accordance with RWHAP statute and policy. The payor of last resort requirement when applied to health care coverage requires RWHAP recipients and subrecipients to consider other sources of premium and cost sharing payment when determining how to operationalize a premium and cost sharing assistance program. Recipients and subrecipients also should work directly with private health insurance issuers, Medicaid, and/or Medicare to coordinate payment of premiums and cost sharing for clients.

Effective Date: June 20, 2018