COUNTY OF LOS ANGELES
Public Health

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To Each Division of HIV and STD Programs (DHSP) Funded Service Provider:

SUBJECT: PROGRAM GUIDANCE 2016.4: CLIENT ELIGIBILITY PROGRAM GUIDANCE UNDER THE BIOMEDICAL PREVENTION CONTRACT

This is to share guidelines and forms that will be used to document eligibility for clients that access the DHSP-supported Biomedical Prevention services at your respective agency. Please note that Attachments I through V, are forms that are completed by the PrEP Navigator or Benefits Enroller and which must be attested to by both agency staff and the client.

Background

On July 23, 2015, the Los Angeles County Department of Public Health's Division of HIV and STD Programs (DHSP) released the HIV/AIDS Biomedical Prevention Request for Statement of Qualifications (RFSQ) to secure a Master Agreement for licensed medical facilities to provide biomedical HIV prevention services, such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to populations at high risk for HIV infection. The goal of the contracts under this RFSQ is to offer additional HIV prevention methods that extend beyond traditional prevention modalities such as sexual health education, HIV and STD testing, and condom distribution, thereby reducing new HIV infections.

Biomedical interventions are increasingly critical components of Los Angeles County's overall HIV prevention strategy, with steadily increasing demand that has not fully been realized. With the expansion of health insurance through the Affordable Care Act (ACA), Los Angeles County residents now have expanded access to a broader range of health services. However, even with health insurance, many clients face high co-payments and deductibles for some services, including PEP and PrEP thereby limiting their accessibility. Moreover, many clients at highest risk for HIV infection in Los Angeles County are unable to qualify for health insurance due to their immigration status.

In order to serve as many clients as possible with financial hardships who are also at the highest risk for HIV infection, DHSP must support a critical biomedical prevention safety net. DHSP is issuing this program guidance to help providers and clients navigate and document the eligibility requirements for Biomedical Prevention Services funded by Los Angeles County.

Basic Eligibility Requirements for PrEP Services in Los Angeles County

In order to access any DHSP-supported Biomedical Prevention service in Los Angeles County, potential clients must meet the following two basic eligibility requirements:

- Be a resident of Los Angeles County, and;
- Have an income at/or below 500% of the federal poverty level.

To access DHSP-supported Biomedical Prevention medical services, such as medical visits and laboratory testing, an individual must also be either uninsured or underinsured.

For purposes of this guidance, uninsured individuals are people who do not have any form of public or private health insurance. Underinsured individuals are people whose health plan does not provide adequate coverage for PrEP health services when adjusted for the individual's income.

Documentation and Frequency of Eligibility Determination

Ideally, insurance information should be reviewed at each visit to ensure that coverage has not changed. DHSP requires that eligibility determinations take place twice a year as long as a client continues to receive services. The first certification is considered the annual certification; the initial annual certification must occur at the time of PrEP/PEP service initiation. The second certification will take place six months later and is considered the six-month recertification.

During the initial and annual eligibility certification episodes, the client must bring all the documentation necessary to determine residency, income, insurance coverage, and medical expenses and complete the *DHSP Eligibility for Biomedical Prevention Services Worksheet* (Attachment I). If there have been no changes in a client's residence, income, coverage, or expenses at the time of the six-month recertification, the *DHSP Biomedical Prevention Services Self-Attestation Form* (Attachment II) may be completed in lieu of the *DHSP Eligibility for Biomedical Prevention Services Worksheet.*

Attachment III, titled *DHSP Biomedical Prevention Services Program Eligibility and Verification,* provides a list of documents that DHSP accepts as proof of client eligibility.

Casewatch and Eligibility Certification

Eligibility information must be entered into the Casewatch data system at a minimum interval of every six months, but should occur sooner if there is a change in residence, income, coverage, or expenses that affect service eligibility. DHSP will not allow agencies to report or bill for services for clients whose eligibility information in Casewatch has not been updated within the preceding six months.

Benefits Navigation

All uninsured and underinsured clients should be referred to and receive benefits navigation services. Benefits navigators are expected to discuss potential health insurance plans with uninsured clients who are eligible for Covered California. In order to document this process, a printout of the potential plan(s) (i.e. Health Net, Kaiser Permanente, Medi-Cal) should be included in the client's medical record. Please refer to Attachment IV as an example.

DHSP appreciates the ongoing commitment of our community partners to provide the highest level of prevention services to persons at the highest risk for HIV infection in Los Angeles County. If you have any questions, please contact David Pieribone, Section Manager, Contracted Community Services at (213) 351-8122.

Very Truly Yours,

Mario J. Pérez, Director
Division of HIV and STD Programs

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Division of HIV and STD Programs Eligibility for Biomedical Prevention Services Worksheet

Basic Eligibility and Documentation

Name:		
DOB:		
MRN:		
Section A: Complete for all clients.	**Y**	**N**
Los Angeles County Resident?		
Client's Annual Income		
Number of Household Dependents		
% Federal Poverty Level	**%**	
If client's income exceeds 500% FPL or is not an LAC resident, STOP- client does not qualify for this program. No need to proceed further.		
To be deemed "uninsured" or "underinsured," must have at least one YES answer :		
Section B: Complete for all clients.		
Is client uninsured and not eligible for medical insurance?	**Y**	**N**
Is client covered by limited scope, restricted, or emergency Medi-Cal?	**Y**	**N**
Is client enrolled in or eligible for My Health LA health care program?	**Y**	**N**
Is client covered by a Bronze-level Covered California plan?	**Y**	**N**
Is client under 26 years old and covered by their parents' or guardians' insurance but, for reasons of confidentiality, does not wish to disclose they are on PrEP/PEP to their parent/guardian?	**Y**	**N**
For PEP Only: PEP site outside of their approved insurance plan (out-of-network)	**Y**	**N**
If yes to any above in Section B, client is deemed uninsured or underinsured. Otherwise complete Section C.		
Section C. Complete if answers in Section B are all NO.		
Using income and medical expense information, does client meet one of the following?		
Eligible for insurance and application submitted and pending		
Annual income between 201-500% FPL and medical expenses > 10% of annual income		
Annual income ≤ 200% FPL and medical expenses > 5% of annual income		
Health plan premium > 9.5% annual income		
Health plan deductible ≥ 5% of annual income		
If yes to any of the above in Section C, client is deemed underinsured.		

** Documentation and substantiation of medical expenses is <u>required</u> on page 2 in order for client to be considered "underinsured."

Underinsured Status Worksheet

Document expenses below to justify "underinsured."	
If uninsured and eligible for Medi-Cal or Covered California (or other options), was an application submitted? If yes, please provide the date.	
Annual Out of Pocket Maximum cost for medical expenses	
Health plan annual premium	
Health plan annual deductible	

Upon signing this document, I attest that, to the best of my knowledge and belief, all information in the above eligibility worksheet reported is accurate and complete.

- If uninsured, I have received and reviewed the insurance options that are available to me and will make every effort to enroll in an appropriate plan.
- I also understand that if I am eligible for Medi-Cal and have not completed the required enrollment paperwork within 6 months of signing this document, I am no longer eligible for medical services through this program.

Client signature: _____ Date: _____

Staff signature: _____ Date: _____

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Public Health

Division of HIV and STD Programs
Biomedical Prevention Services
6-Month Self-Attestation of Continued Eligibility

Client ID# _____

Date:

Dear Client,

Your program eligibility is due for renewal on: _____/_____/_____. Please follow the steps below to complete and submit this form before the expiration date.

STEP 1- Review and Verify Your Eligibility Information

BELOW IS THE INFORMATION LAST REPORTED BY YOU		Is the eligibility information still the same?
(Input Information)	Is still my residential address	o YES o NO
(Input Information)	Is still the insurance coverage for health services I am enrolled in:	o YES o NO
$ (Input Information)	Is still my annual income:	o YES o NO

If you marked "YES" in all three (3) boxes above: (A) Read and sign client acknowledgement in STEP 2 (below):

If you marked "NO" in any of the three (3) boxes above: You must inform the Benefits Navigator who will update your eligibility information and determine if you remain eligible for services.

STEP 2 - Read and Sign Acknowledgement

Client Acknowledgement of Understanding

The information provided above is evidence of my intention to recertify for the program. I understand that I may be denied program services if I have given false information or fail to give complete information by the eligibility expiration date highlighted above. By signing below, I certify that to the best of my knowledge the information provided is true and correct.

Client Signature: _____ Date: _____

Division of HIV and STD Programs Biomedical Prevention Services Program Eligibility and Verification

Los Angeles County Residence	1) Rental or Lease Agreement 2) Mortgage Statement 3) Utility Bill 4) Government issued letter 5) Bank Statement 6) Support Verification Affidavit (see Attachment V) 7) Homeless Verification Affidavit 8) Valid California Driver License or California Identification card 9) Consular identification card 10) Student ID cards with expiration date
Verification of income	1) Bank Statement 2) Pay Stub(s) for 1 full month of wages 3) Disability Award Letter (SSI/SSDI) 4) Benefit Receipt or Check Stub 5) Self-Employment Affidavit (see Attachment V) 6) Most Recent Tax Return
Verification of insurance	1) Confirmation of coverage if insured or underinsured (e.g. Insurance card and/or Explanation of Benefits) **AND** 2) Denial letter from Medi-Cal or print out of computer screen shot

Example of Potential Covered California Plan

Silver 70 Plan Details

Available Plan Benefits in blue are subject to medical deductible

Copays in Black are Not Subject to any Deductible and Count Toward the Annual Out-of-Pocket Maximum

Before selecting a plan to enroll in, always check the plan's Summary of Benefits and Coverage (SBC) and Evidence of Coverage (EOC) documents for specific costs. There may be variations between products that are not reflected here.

STANDARD BENEFITS FOR INDIVIDUALS

Key benefits	Silver 70
Individual Deductible	$2,250 medical deductible $250 pharmacy deductible
Family Deductible	$4,500 medical deductible $500 pharmacy deductible
Preventative Care Copay[1]	no cost
Primary Care Visit Copay	$45
Specialty Care Visit Copay	$70
Urgent Care Visit Copay	$90
Tier 1 (most generics) Drug Copay	$15
Lab Testing Copay	$35
X-Ray Copay	$65
Emergency Room Facility Copay	$250
High cost and infrequent services (e.g. Hospital Stay)	20% of your plan's negotiated rate
Hospital Stay Physician Fee	20% of your plan's negotiated rate
Tier 2 (preferred brand) Drug Copay after Pharmacy Deductible (if any)	$50
Tier 3 (non-preferred brand) Drug Copay after Pharmacy Deductible (if any)	$70
Tier 4 (specialty drugs) cost share after Pharmacy Deductible (if any)	20% up to $250 per script after deductible
Maximum Out-of-Pocket For One	$6,250
Maximum Out-of-Pocket For Family	$12,500

[1] In-network only

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Division of HIV and STD Programs
Biomedical Prevention Services
Support, Homeless, and Income Verification Affidavit

Client ID: _____

Date:

I, _____, declare to _____ that I am:
(Client name) (Clinic/Agency name)

Check (✓) if applicable		
	Supported or employed by: _____ My salary is $ _____ per _____. (Amount/ if applicable) (Month)	The person/agency listed provides me with the following (Check all that apply): o Shelter o Food o Cash
	I am homeless.	

Client Acknowledgement of Understanding:

I am providing information in this completed form to qualify for Biomedical Prevention Services. I understand that I may be denied program services if I have given false information or fail to give complete information. By signing below, I certify that to the best of my knowledge and or/belief the information provided is true and correct.

Client Signature: _____ Date: _____