New Mexico Department of Health
Public Health Division
HIV Services Program

Program Policies and Procedures Manual

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Purpose and Goals of the HIV Service Provider (HSP) Network

This Program Policies and Procedures Manual is intended to describe clear and consistent processes and guidelines for all HIV-related care and support services funded and supported by the New Mexico Department of Health (NMDOH). These policies were developed by the HIV Services Program for all services that it supports. The HIV Services Program is part of the Infectious Disease Bureau (IDB), which is part of the Public Health Division (PHD) within NMDOH.

The NMDOH HIV Services Program funds and supports the HIV Service Provider (HSP) network across the State of New Mexico to ensure excellent health outcomes for persons living with HIV. The network aims to contribute to the goals of the *HIV National Strategic Plan: A Roadmap to End the Epidemic: 2021 – 2025* (https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025) and the *New Mexico Integrated Plan for HIV Prevention and Care: 2017 – 2021*, which will be replaced by a new plan in December 2022. All funded services in the network should contribute to the Vision stated in that plan.

New Mexico will be a place where 1) new HIV infections are prevented, 2) persons with HIV know their status and are retained in high quality care so they can achieve their full potential across the life span, and 3) barriers, stigma, discrimination and disparities are eliminated. This will achieve health equity for all persons impacted by HIV regardless of race/ethnicity; sexual orientation; gender, gender identity, and gender expression; age; socio-economic circumstance; disability; language; immigration status; religion, spirituality and cultural tradition; and geographic locations including rural, frontier and tribal areas.

The HSP network contributes to this Vision by ensuring equitable access to a comprehensive array of HIV medical care and support services in all Public Health Regions. This is done by providing funds to one-stop HSP network agencies to cover all areas. These services are supported via contracts for additional medical and support services that respond to statewide and regional gaps, such as ambulatory medical care, dental services, housing, food and nutrition services, and emergency financial assistance.

The HSP network is supported with a variety of funding sources, the largest of which is federal dollars under Part B of the Ryan White legislation. While state general fund and program revenue dollars also play a big part, program policies are designed to comply with Ryan White and state rules and regulations, regardless of the mix of funds for any activity. Therefore, this manual applies to all funds and services with the intent of complying with guidelines and principles of Ryan White, which set high standards for service quality and ensuring that activities contribute to national and state goals.

Persons who enroll and are deemed eligible for the HSP network can access an array of services. However, their service mix is not an entitlement assured to all enrolled clients. Instead, case managers assess each client's individual needs and barriers to care. This assessment is used to develop an individualized and client-centered care plan. That care plan aims to reduce barriers and challenges that may hinder an individual's ability to access and be retained in ambulatory medical care to remain adherent to their HIV care plan and anti-retroviral therapy (ART) medications. It incorporates a mix of services provided directly and/or via referral that can help overcome these issues.

The HSP network supports many of the services that are identified in client care plans. As the payer of last resort, Ryan White dollars in this network are not accessed until outside resources have been

reasonable pursued. These dollars ensure that there are no gaps and wrap-around services are available. As these services are delivered, it is anticipated that clients will have better access to care and improved adherence, leading to better individual health outcomes.

NMDOH strives to ensure that access is equitable, both geographically and based on the diverse demographics of persons impacted by HIV in New Mexico. For that reason, funds have been awarded to at least one multi-service, one-stop HSP network agency in each Public Health Region. While it may be most convenient for many individuals to access the closest HSP network provider, enrolled clients may select their own providers based on their individual needs and preferences.

Clients must be enrolled with one and only one HSP agency as their primary provider, where they receive Medical and/or Non-Medical Case Management. This ensures that there is not duplication and that each client has a single care plan to fulfill their needs and reduce barriers to care. However, to ensure client choice and access to all needed services, clients may receive other medical or support services from other HSP agencies or other program contractors via referral from their primary HSP.

The HSP network is guided by policies and regulations to ensure that services follow best practices, including offering state-of-the-art HIV medical care. All provider agreements and other contractual relationships are monitored by the NMDOH HIV Services Program to ensure compliance with federal Ryan White Monitoring Standards and state policies. In addition, the statewide Clinical Quality Management (CQM) plan reviews client outcomes across several variables and implements processes to improve these results.

Resources

NMDOH HIV Services Program web page:
https://nmhealth.org/about/phd/idb/hats/

New Mexico HIV, STD and Hepatitis Resource Guide
www.nmhivguide.org
http://espanol.nmhivguide.org/

Definitions and Glossary

ADAP Bridge – ADAP Bridge Program provides support for HIV related medications for clients who are currently uninsured and who are in the process of applying for insurance coverage. It is one element of the overall ADAP that is a short-term solution to get clients their medications quickly. A Bridge provides a 30-day fill of HIV related medications. An addition Bridge may be requested however these are determined on a case-by-case basis and approved by the HIV Services Program Manager. The ADAP Bridge is an integral part of the Rapid Start process. As per the Enhanced Formulary, HCV medications are not covered by this process.

ADAP Enhanced Formulary – The ADAP Formulary is a list of medications that can be covered by various elements of the ADAP Program including IAP and the ADAP Bridge. Effective July 1, 2018, the New Mexico ADAP no longer has a specific list of medications that are included in a standardized "formulary". Instead, the state will use an Enhanced Formulary model. Under this model, any FDA-approved medications could be considered for coverage depending on the patient's needs, prescriber's recommendations, and specific health insurance coverage (SEE *New Mexico AIDS Drug*

Assistance Program (ADAP) Enhanced Formulary to Improve Medication Access https://www.nmhealth.org/publication/view/general/4529/.

AIDS Drug Assistance Program (ADAP) – The term ADAP is used in two different ways in New Mexico.
1) ADAP is a stream of federal funding under the Ryan White legislation. These funds are narrowly earmarked and can only be used to ensure access to medications for persons living with HIV.
2) ADAP funds are used in New Mexico for several different services used to help persons with HIV access their medications. The two most frequent program strategies are the "ADAP Bridge Program" and the "Insurance Assistance Program (IAP)", both described in this glossary.
3) Person applying for ADAP must provide a current, with in one calendar year, viral load documentation. (See Section 2, Client Eligibility)

Client – A person living with HIV (PLWH) who has met eligibility requirements and is currently enrolled in the HSP network.

Closure/Disenrollment – The process to remove eligibility for services for an individual who was enrolled in the HIV Service Provider network. This will occur if enrollment is not completed by the end of the 1-year eligibility period. It also will occur if a client has a change in circumstances that make them ineligible, such as moving out of the state or exceeding the 400% poverty level cap. A Closure form must be submitted to the HSP Liaison and indicated through e2NM Activity Status in e2NM.

Dental Assistance Program (DAP) – A statewide program that offers dental services to clients as a last resort after other funders are used and for persons who are uninsured or underinsured. This program is supported by NMDOH entirely with state general fund dollars.

Department – The New Mexico Department of Health (NMDOH).

Eligible Client – A person living with HIV who meets all qualifications and is deemed eligible to enroll in the HSP network. Eligibility is based on 1) proof of HIV status, 2) residence, 3) income and 4) health insurance status. Insurance status includes enrolled in Medicaid, Medicare, ACA, Private/Employer, Underinsured and uninsured.

Enrolled Client – A person who has completed enrollment and determined to be eligible for services. An individual remains enrolled for one year.

Enrollment – The process for a person living with HIV (PLWH) to be determined eligible to receive services from the HSP network.

e2NewMexico (e2NM) - e2NM is an electronic health and social support services information system for HIV Services Programs supported by RDE Systems and the NMDOH HIV Services Program. The system is used to generate the Ryan White HIV Services Report (RSR) and AIDS Drug Assistance Report (ADR) in addition to monitoring quality of care. e2NM provides real time eligibility determination which aids case managers in providing *Rapid START (See Rapid START)* for newly diagnosed clients or those who have fallen out of care and wish to re-establish. It tracks current spending on services by HSP's and generates an expense report used to bill the Program for services rendered. e2NM contains customizable modules for determining real time eligibility, tracking demographics, services, medications, laboratory test results, immunization history, diagnoses, and HRSA HAB required measurements (viral load, prescription of Anti-Viral Treatment (ART) and medical visits). e2NM was developed on the eCompas (electronic Comprehensive Outcomes

Management Program for Accountability and Success) RDE Systems plat form and the Program. e2NM replaced CAREWare in September of 2021.

Federal Poverty Level (FPL) – FPL guidelines are issued each year by the federal Department of Health and Human Services (HHS). They establish the amount of income based on household size that categorizes an individual or family as being low income. In New Mexico, income must be below 400% to be eligible for services within the HSP network.

HRSA HIV Aids Bureau (HRSA HAB) Performance Measures - Performance measures are an indication of an organization's performance in relation to a specified process or outcome. HRSA HAB Performance Measures were developed to help Ryan White HIV/AIDS Program agencies monitor and improve the quality of care they deliver. The NMDOH HIV Services Program monitors three (3) performance measures: viral load, prescription of Anti-Viral Treatment (ART) and medical visits/gaps in care. Performance Measures can be found: https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio

Health Insurance Premium (HIP) – HIP coverage is similar to IAP, in that it provides support for clients to receive ambulatory medical care via securing health insurance. Because IAP can only pay for services and activities that directly related to medications, some costs that are ineligible under IAP can be covered under HIP. For example, if a client has their insurance premiums paid by IAP but still has costs for ambulatory medical visits, these costs can be covered via HIP including visit co-pays, co-insurance, and deductibles. HIP can also be used to secure the insurance binder payment for newly enrolled clients.

Health Resources and Services Administration (HRSA) – HRSA is the federal agency responsible for overseeing and making funding awards under the Ryan White program. Ryan White is managed by the HIV/AIDS Bureau (HAB) within HRSA.

High Risk Pool – The New Mexico Medical Insurance Pool (NMMIP) is a high-risk insurance pool that serves persons who are ineligible for other insurance options. *See NMMIP.*

HIV Service Provider (HSP) agency – An HSP agency is an organization that is funded by the NMDOH HIV Services Program via a provider agreement to offer a range of medical and/or support and social services to persons living with HIV. While HSP agencies are designed to be "one stop" locations for services, not all HSP agency partners are funded for the full range of medical and social services due to varying capacity and needs in their areas. One HSP agency is not funded via a provider agreement, but rather operated directly by NMDOH, namely the Community Collaborative Care (CCC) Program in Las Cruces. For the sake of these policies, all information that applies to HSP agencies (except those about billing) apply to CCC as well.

HIV Service Provider (HSP) Network – A network designed to ensure access to medical care and support services for persons living with HIV, regardless of where in New Mexico they live. An eligible client can enroll in this network at any HSP agency that offers Medical Case Management. While their enrollment is active and current, a person living with HIV can access services at any HSP agency of their choice as long as there is not duplication. While persons may prefer the HSP agency closest to their home, they are not required to receive any or all services from that organization.

Insurance Assistance Program (IAP) - IAP is a service for persons who are eligible and enrolled in New Mexico's ADAP. It is designed to secure medications for clients in a cost-effective way by helping them to secure and pay for health insurance. IAP has been determined to be much more

cost effective on average per client than direct dispensing such as via the ADAP Bridge. IAP can cover health insurance premiums, as well as co-pays, co-insurance, and deductibles for medications.

Liaison – Staff member within the NMDOH HIV Services Program assigned to be the primary contact for each HSP network agency. This is the first point of contact for HSP agency case managers to call with questions about client enrollment or needs.

Medical Case Management – A service category provided as part of the HIV Service Provider network. Medical Case Management (MCM) is a client-centered activity that assists with accessing and being retained in medical care to improve health outcomes. Medical Case Management services (including treatment adherence) are designed to ensure timely and coordinated access to medically appropriate levels of health and support services, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and other forms of communication and activities. Medical case management involves working with healthcare professionals and others in the community to assess patients' health and oversee plans to manage their conditions and progress. Duties can include planning how to successfully place patients, along with performing frequent reviews of their cases. Client enrollment may only be completed via Medical Case Management providers so all enrolled clients must access this service as needed.

New Mexico Department of Health (NMDOH) – NMDOH is the centralized health department for the State of New Mexico. In this policy manual, references to NMDOH typically mean the HIV Services Program within the Infectious Disease Bureau and the Community Collaborative Care (CCC) Program in the Southwest Region. Both are within the NMDOH Public Health Division (PHD).

New Mexico Medical Insurance Pool (NMMIP) – The New Mexico Medical Insurance Pool (NMMIP) is a high-risk insurance pool that serves persons who are ineligible for other insurance options. Prior to implementation of the Affordable Care Act (ACA), most persons living with HIV in the state had insurance from NMMIP, as they were excluded from other insurance due to HIV being a “pre-existing condition”.

HIV Contractor Organization – The NMDOH HIV Services Program also has provider agreements to fund other organizations that are not “one stop” HSP agencies. These organizations typically only receive funding for one or two specific services, such as dental care, ambulatory medical care, and emergency financial assistance. While they are not points for conducting client enrollment, they can serve eligible persons living with HIV who are referred by an HSP agency and receive reimbursement from NMDOH via their provider agreement.

Payer of Last Resort – A requirement under Ryan White that funds may not be used for any item or service for which payment has been made or can be expected to be made by another payment source. Alternative payment sources must be reasonably pursued before billing the Program.

Person Living with HIV (PLWH) – A person who has HIV infection, including those who have received a diagnosis of AIDS.

Provider Agreement (PA) – A provider agreement is a specific type of contractual instrument allowed by State of New Mexico Procurement Code. It is normally used to purchase medical and health services. Because this type of agreement falls under the state’s Health Care and Hospital Exemption, it is not subject to all the same requirement as a Professional Services Contract (PSC) and has greater flexibility. The NMDOH HIV Services Program has many PA agreements to ensure flexibility in responding to the needs of persons living with HIV.

Rapid Start - Rapid START is an intervention model to immediately link patients to care and to initiate ART, ideally on the same day of the preliminary HIV diagnosis. Rapid START initiation should be offered to all people newly diagnosed with HIV and those who are living with HIV who have fallen out of care and are wanting to re-engage. A preliminary positive from a state approved point of care test can be recognized as a preliminary HIV confirmation. The purpose of Rapid START is to initiate HIV treatment as quickly as possible which has shown to significantly improve the individual's health outcomes. It is a paradigm shift in how HIV is treated. The HIV Services Program began Rapid Start in 2020 and strives to make this the norm statewide.

Resident – An individual who physically resides in the State of New Mexico on the day that an enrollment was submitted and/or on the day the final determination of eligibility is made. This person has demonstrated intent to remain within the state.

Ryan White Part B – The HSP Network is funded with a variety of federal, state and program revenue funding sources. The primary source of federal funding is Part B under the Ryan White legislation, which is awarded to all states based on a formula from the Federal Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

Standard of Care – Standards of Care outline the elements and expectations that all HSP's and other contract providers must follow when implementing a specific service category. The purpose of service standards is to ensure that all agencies offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that all providers in New Mexico must achieve. The Standards of Care were put in place in 2018 and should be updated every two years.

State Pharmacy – The state pharmacy is the ADAP-specific pharmacy operation that is fully supported by the NMDOH HIV Services Program. It provides all medications under the ADAP Bridge. It can serve any clients for whom insurance support is provided via IAP, including persons with NMMIP insurance. At the current time, the state pharmacy is operated by Southwest CARE Center via a contractual relationship with NMDOH.

Suppressed Viral Load – *See viral suppression.*

Treatment Adherence – This means following a medical treatment plan. For HIV in particular, adherence means that a client is taking their HIV-related medications exactly as instructed by their medical provider.

U=U - U=U is an informational campaign about how effective HIV medications are in preventing sexual transmission of HIV. U=U means "Undetectable = Untransmittable," indicating that if a person with HIV is on HIV meds (antiretroviral therapy, or ART) with a consistently undetectable HIV viral load, the virus cannot be transmitted to a sex partner. As a prevention strategy, this is often referred to as Treatment as Prevention.

Viral Suppression – Viral suppression happens when treatment for HIV reduces the amount of virus in the blood enough that it cannot be detected via regular laboratory testing. This is also known as having a suppressed viral load. Viral suppression is a major goal of the HSP network and all Ryan White funded services, as it means that a client is likely to have the best clinical outcomes. Persons who sustain viral suppression cannot pass HIV, sexually, to others. Viral suppression is measured as <200 virus copies/ml

Program Policies

1. Information and Data Confidentiality, Privacy, Security and Retention

Confidentiality and client privacy are of paramount importance in the provision of services to persons living with HIV. These provisions apply to all HSP agencies as well as other HIV contractor organizations funded by the NMDOH HIV Services Program.

All funded HSP agencies shall retain records and ensure their privacy and security in compliance with these policies, any regulations under the Ryan White legislation, and their own organizational policies. Providers must create and establish their own security, privacy, data storage and data retention policies, protocols and/or procedures. These may be more stringent than, but at minimum must comply with, those of NMDOH. Where these standards differ, agencies shall use the most stringent policies for information security and the longest duration for record retention.

All HSP employees and volunteers with access to client information must receive routine training on these procedures, at least annually. At a minimum, training must cover 1) confidentiality, 2) data and information security, 3) the proper exchange of information, and 4) required client consent for data use and release. Documentation of training must be maintained in personnel records.

All client-level information shall be retained for at least three years from the date of service. This shall be both for medical services and support services. Information generated electronically such as electronic medical records (EMR) and the e2NM system shall be retained in electronic format. Information generated through paper records such as visit notes or client charts must be retained in paper format for at least three years, even if this information is scanned into an electronic system.

After this period of retention, paper records may be archived and/or scanned into an electronic format and destroyed. Any archiving must ensure the same standards of information security as active records.

All records containing information on services provided to persons living with HIV or that contains information related to their health status shall be stored in a means that is secured with a “double lock” format. In other words, two keys must be used to reach this information. For example, a locked file cabinet in a locked room would suffice, if there is not another method of access (i.e., a first-floor window into that room). If a locking cabinet is not available, a locking room within a locking office suite would suffice for this requirement. These areas should be marked noting that they contain confidential information.

When in use, documents should be kept in a manner that does not allow incidental or accidental observation by non-authorized users. Documents with confidential information must not be readily observable by non-authorized persons when they pass through an office, sit at desks or approach reception areas. Unauthorized persons shall not be left unattended in areas where confidential or sensitive information is maintained. When documents must be removed from a secured area for use, this should be done in a way that minimizes the chance of being compromised. They must contain the minimum amount of confidential information necessary to do business. Where possible, records should be coded to disguise any information that could easily be associated with HIV/STD and/or the identity of an individual. Documents with HIV confidential information should be returned to their secured storage immediately after their use has been completed.

When documents are to be destroyed after the stated retention period, this must be done using a shredder that is of commercial quality and has a crosscutting feature before disposing of them. HIV confidential documents to be shredded must be always under the direct control of an authorized staff member. Staff is responsible for personally shredding HIV confidential documents.

The use of electronic systems to gather and store client information requires specific safeguards. These are to avoid breaches of confidentiality and protect clients' right to privacy. The following standards must be followed for all systems that contain information on clients living with HIV and services provided to them.

- Computer monitors must be positioned to prevent unauthorized viewing.
- All computers including laptops that access and store confidential information must be password protected.
- Communications among systems and servers storing client-level data must be encrypted.
- Laptops containing confidential information must be returned to a secured area at the end of the working day and never stored in an unsecured, unauthorized area. This directive includes storing laptops in the employee's car, car trunk, or home unless there is prior supervisory approval.
- Deleting files from a computer hard drive is not necessarily sufficient if the computer is to be stored. Hard drives must be wiped. If you are unsure how to do this or what it means, consult with information technology (IT) staff.

All HSP agencies as well as other HIV contractor organizations funded by the NMDOH HIV Services Program must have organizational policies that reference and comply with the Health Insurance Portability and Accountability Act (HIPAA). Clients must be provided with written copies of such policies, as specified by the organization.

Per HIPAA, client information is obtained and shared only with those agencies that are providing or paying for care. As a funded, the NMDOH HIV Services Program may request or inspect client information including medical records.

Information provided by clients may be verified with outside sources. All enrolled persons should be made aware that the HSP agency and/or NMDOH HIV Services Program may contact other federal, state and local government entities that offer services to confirm information. For example, information from the state's Medicaid may be reviewed when determining eligibility for AIDS Drug Assistance Program (ADAP) services.

2. Client Eligibility

All services offered by the HSP network will only be reimbursed by NMDOH if they are provided to persons living with HIV (PLWH) who are determined to be eligible for the program. Services must be provided during the approved enrollment period, not to exceed one (1) year after which the client and case manager must complete and submit another enrollment. Eligibility periods and approvals come solely from the NMDOH HIV Services Program.

Individuals are eligible for enrollment if they meet all the following criteria.

- Documentation of HIV through a lab report identifying HIV positivity (does not have to be current if only enrolling in HSP), current prescription of Anti-Retroviral Treatment (ART) medication, and or documentation of HIV status provided by a physician or mid-level practitioner. Clients who wish to participate in ADAP must present a lab with HIV status collected within the past 12 months. Documented viral load must be entered into e2NM as soon as it is available.
- Proof of residency within the State of New Mexico.
- Documentation of household income that is at or below 400% of the Federal Poverty Level (FPL). *[See Section 5. Documentation of Income.]*
- Additional documentation of medical insurance options and coverage is required for some service categories, including the Insurance Assistance Program (IAP) and ambulatory medical care.

Note: As of April 1, 2017, NMDOH no longer has an asset test for eligibility in HSP network services. The requirement for a person to have liquid assets less than ten thousand dollars ($10,000) has been eliminated.

Services provided as part of the HSP network are eligibility programs and not entitlement programs such as Medicaid and Medicare. Therefore, the services provided by the HSP agencies are subject to accessibility, availability, and funding statewide. This means there may be some services which are not provided in a Public Health Region or specific HSP office but are available elsewhere in the state.

By statute, Ryan White 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 (e.g., Medicaid, Medicare, other state, or locally funded programs, and/or employer-sponsored health insurance). As such, all HSP network agencies are expected and required to vigorously pursue eligibility for other funding prior to delivering services. This ensures that the state extends finite grant resources to ensure that all enrolled clients can have their needs met. The requirement to be payer of last resort is particularly applicable to ADAP services, as clients may have several options to pay for ambulatory medical care and/or medications. Policy Clarification Notice (PCN) 16-02 Allowable Costs and PCN 21-02 https://ryanwhite.hrsa.gov/grants/policy-notices

Documentation of Residency

Documentation of New Mexico residency is required for enrollment in the HSP network. A physical address within the state is required. If the client has a different mailing address, this information should be provided as well. The address of the HSP network agency should not be provided for either the physical or mailing address.

Residency is defined as an individual who is physically present in the State of New Mexico on the day that an enrollment or re-enrollment application was submitted and/or on the day the final determination of eligibility is made. The individual also must demonstrate and/or communicate intent to remain within the state.

Residency may be documented by providing any one of the following.

- Current New Mexico driver's license or identification card that is valid on the date of the enrollment application.
- Copy of a rental lease from a landlord (not an agency providing rental support) with a New Mexico Street address in the name of the client or their legal spouse. Lease must be current, OR where the term has expired and has converted to month-to-month, if the end date of the initial term is no more than six months prior to the date of application.
- Copy of a current electric, gas or water utility bill with a residence address (not a post office box) in the name of client or their legal spouse. Phone, internet, and cell phone bills are not accepted as proof.
- Proof of home ownership with an address within the State of New Mexico, such as a mortgage bill or property tax statement. The stated home residence address must match the address of this property.
- Social Security award letter sent to a New Mexico Street address (not post-office box).
- Pay stub with a New Mexico Street address (not post-office box).
- For persons who are experiencing homelessness, are living in transient situations, and/or do not have stable housing, an affidavit signed by the individual (or their legal guardian) and counter-signed by the HIV case manager attesting to being a current resident within the state. Such attestation should only be used when the client is not stably housed. It should never be used due to a lack of required documentation for an individual who has stable housing.
- If the individual cannot provide the above documentation, consult with your HSP liaison prior to enrollment into the program to discuss the individual's specific case. The HSP liaison will advise providers as to what will be accepted by the program.

If staff of the NMDOH HIV Services Program has reason to believe the applicant may not reside in New Mexico, additional proof of residency may be requested prior to approving the enrollment.

Established residents of the state are expected to be in state to receive services, other than travel of short duration. If an enrolled client will be out of state for more than 60 consecutive days, they must inform their case manager who must inform the NMDOH HIV Services Program. With advance notice and justification, an individual who will be out of state for longer than 60 days can remain enrolled but have a "lapse" in their services during which they are ineligible for any support. If there is not notice or the client has no justification for the long absence, the client will be dis-enrolled and can reapply for services when back in the state. This is true even if the client maintains a primary residence in the state.

Eligibility is not dependent on immigration status. Individuals do not have to document U.S. citizenship or immigration status to be eligible for services. However, all persons must show that they are residents of New Mexico.

3. Client Enrollment

All persons who wish to receive services from the HSP network must first complete enrollment in e2NM to include all supporting documentation (HIV status, Residency, Income & Insurance). e2NM will determined client eligibility based on the information entered. The client is enrolled in the program once eligibility is determined.

One key advantage of the new e2NM system is that it can determine eligibility in real time. If documentation is missing after this initial determination, the HIV Services Program gives five (5) business days to submit any additional or corrected documentation or information. This window allows case managers and clients to work together to submit the proper documentation without affecting eligibility. Clients will be deemed ineligible after the fifth day if the required documents are not uploaded into e2NM.

Information entered into e2NM consists of documentation of residency in New Mexico, income verification, insurance documentation and current (with in the calendar year) HIV lab results, current ART prescription and/or HIV verification from a doctor or nurse (ADAP eligibility has different requirements). Enrollments that lack this supporting information will deme the client ineligible for the Program. HSP Liaisons with the NMDOH HIV Services Program will inform the submitting case manager or another contact person within the HSP network agency of any out-of-date or missing documentation. The case manager or contact person has 5 working days to upload missing, out-of-date, or incorrect supporting documentation. The client will be deemed ineligible after the 5-day window if documents are not present in the e2NM Document Tracker.

Collection of supporting documentation including proof of income can be time consuming and challenging for clients, particularly those who are unstably housed or have barriers to care such as behavioral health issues. Because there is no grace period, this process should start early enough to ensure timely completion for eligibility. *Case managers are strongly encouraged to start the enrollment process at least 4-6 weeks before the end of eligibility for each client.*

e2NM provides information on client eligibility with enrollment dates, to assist HSP network agencies in maintaining current enrollments for all clients. However, regardless of what is provided by e2NM, ensuring ongoing enrollment with no gaps in services is solely the responsibility of the HSP network agency selected by the client. All HSP agencies should have a tracking and reminder system that creates an alert roughly 4-6 weeks before the end of enrollment for each client.

Best practice is for the enrollment process with all supporting documentation to be entered during an in-person visit. When possible, coordinating this appointment with a doctor's visit or other service poses the least burden for clients.

During the enrollment visit, each case manager of an HSP network agency should provide basic information to all clients. This should include the following, at minimum, tailored to information and support needed by the client.

- Copy of NMDOH *HIV Care and Services Guide,* which is available in English and Spanish. Electronic copies of the guide can be found on the NMDOH HIV Services Program web page (https://nmhealth.org/about/phd/idb/hats/) and online resource guide (www.nmhivguide.org). This includes a description of the range of services that are available.
- Written or verbal information about program eligibility requirements.

- Copies of "*HIV Services and Enrollment Choice Form", as applicable. (See Section 6. Client Choice)*
- Information and reminder about the need for enrollment every 12 months.
- Information about the need to provide timely information back to their case manager about any changes that can impact their eligibility, such as significant changes in income or change in residency. This should be done within two weeks.
- Copies of HIPAA privacy and confidentiality forms, as well as consent forms for release of information. These can be agency-specific or agency-developed forms, as NMDOH does not mandate any specific format however the release must meet all HIPAA requirements. These need to be uploaded into e2NM
- Copies of the organization's grievance policy and/or forms for submitting written grievances.
- Information about client rights and responsibilities within the HSP network. A condensed version of this information is included in the *HIV Care and Services Guide*. *[See Section 12. Client Rights and Responsibilities for more information.]*

Case managers should strive to complete enrollments as quickly as possible. If there is an urgent need, such as a Rapid START, case managers are strongly encouraged to make contact with their liaison and/or the ADAP Coordinator within the HIV Services Program to expedite the enrollment and Bridge processes.

- Case managers should strive to secure all information to complete the enrollment. Typically, the only section that can't be completed during the client visit is "Part C – Medical" which must be completed by a clinician.
- Five documents must be uploaded to e2NM to complete the eligibility process. 1) Proof of Residency, 2) Proof of Income, 3) Proof of HIV Status, 4) Proof of Insurance, 5) Consent for e2NM. The client will be deemed ineligible and not able to receive services if all documents are not uploaded during enrollment.
- e2NM determines eligibility in real time as the case manager is completing the enrollment. Case managers will be informed by e2NM if a client is eligible or ineligible for services based on the information provided to e2NM. e2NM will inform the case manager of the reason(s) why a client is deemed ineligible.

Disenrollment

Clients may be dis-enrolled from the HSP network and all services, including ADAP, under several circumstances.

- The individual no longer resides in New Mexico.
- The individual has died.
- The client's household income rises above the level where they qualify for services in the network.

- The client has deliberately reported false information on a re-enrollment or six-month re-certification application and this information can materially impact eligibility.
- The client violates the Rights and Responsibilities in a manner that is inappropriate or abusive
- Voluntarily withdrawals due to other circumstances.

5. Documentation of Income

The HIV Service Provider (HSP) network is designed to serve persons at greatest need, so eligibility requires that an individual is low income. For the program in New Mexico, eligibility is for those who have a household income that is at or below 400% of the Federal Poverty Level (FPL).

For all clients, documentation of income is required at enrollment. Case managers must verify there has not been a significant change in client's income that would impact eligibility throughout the enrollment year. Case managers must notify their appointed Liaison if the client's income has changed prior to the next enrollment.

While eligibility is not reviewed at times other than enrollment, it is the responsibility of all enrolled clients and/or their case manager to keep the program updated. Clients are expected to inform their case manager at the HSP agency where they enrolled of any significant change (increase or decrease) in their household income. This should be done within one week. This ensures that services are not provided when an individual was ineligible so that costs don't have to be recaptured.

Financial eligibility is based on gross income. This includes 1) employment income, 2) self-employment income, and 3) unearned income (unemployment, inheritance, gambling winnings) for the client and other members of the household. For persons who have multiple employers and/or changes in income sources over the course of the year, the most recent Federal Tax Return is required to supplement documentation provided below.

Clients who state that their household has zero income are not required to provide the documentation below. Instead, they must provide a "zero income attestation" that clearly defines the housing arrangement, household members and relationships. That statement must be signed by both the client (or their legal guardian) and the case manager who is providing enrollment assistance. The NMDOH HIV Services Program may implement a form or standardized language that is required for the "zero income attestation". If the client with zero income is being supported by another individual who is not financially responsible for them, a letter from that person must be attached to the statement.

Definition of Household Size and Household Income

Client eligibility is based on the total income of the household, as well as the number of individuals in the household. The following definitions apply.

- Household size includes any children less than 18 years of age in the household for whom the client is financially responsible. This excludes foster children for whom the client receives foster care income.

- Income and household size both include all people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room ***and that contribute*** to the care and treatment of the individual. Care and treatment include shelter, food, medical expense, and any other expenses incurred by or on behalf of the individual. This only includes parents, stepparents, parents-in law, spouses, significant others, and domestic partners.
- Total household income is the sum of money received in a calendar year by all members of the household combined. Food stamps are not considered income. Financial Aid and/or student loans received by individuals attending school is not considered income.
- There must be documentation of income from all persons aged 18 or older who are included in the household size to determine a "household income".

Spousal Income

Spousal income must be reported and documented for any client who is reported as married or domestic partner. This must be included in e2NM. The documentation requirements are the same as those for the client.

If the couple is separated or divorced, this should be noted. In that case, spousal income is not reported, and the spouse is not included in the household size.

If the spouse has no income, a "zero income statement" is required for the spouse.

In cases where there is domestic violence and the couple is separated, spousal income can be excluded. The Liaison must be informed of the request or situation and documented, without detail, in e2NM.

Employment Income

For individuals with regular, non-seasonal employment, documentation must be with the three most recent consecutive paystubs. The most recent pay stub can be no more than 30 days older than the date that the application was signed by the client.

For clients employed seasonally by the same employer, documentation should be a current paystub that shows year to date earnings.

Employment income includes any overtime pay, tips, bonuses, and commissions. All must be reported.

Persons who have multiple employers and/or job positions over the course of the year make it difficult to calculate annual income. In these cases, income documentation must be supported by providing the most recently filed Federal Tax Return.

If the categories of employment income described above do not apply to a specific individual, the case manager should contact the HIV Services Program liaison for their HSP agency to determine the appropriate documentation that will be required.

Self-Employment Income

Self-employment income is calculated based on the previous year's federal tax return and current CRS forms.

- Determine the percentage deduction by using Schedule C from the prior year's Federal Tax Return. Calculate the percentage of business income by dividing line 12 from the first page of the IRS Form 1040 *(this is Business Income or Loss)* by line 1 of the Schedule C *(this is Gross Receipts or Sales)*. The percentage calculated here is the percentage of gross receipts that was business income, after all deductions.
- Add the gross receipts from the CRS forms for the full 6-month period. Then multiply the total by the percentage calculated above and divide by 6, to estimate the monthly business income.

Regardless of the filing frequency of CRS forms, clients must provide the most recent six months of CRS receipts. In the case of those who file semi-annually, six months is documented on a single form. For those filing monthly, six individual monthly forms would be needed.

If Line 12 of the Form 1040 indicates a business loss *(a negative amount is reported)*, consult with the liaison assigned to the HSP agency for guidance on calculating income prior to submitting the application.

Income Not from Employment

The following types of income that are not from employment must be documented to determine eligibility. Recommended documentation is noted for some sources.

- **General Assistance or TANF:**
  Preferred documentation: A recent printout of payments made within the past three (3) months prior to the application date.
  Alternative documentation: The most recent determination letter
- ***Pension or retirement benefits:***
  Preferred documentation: A statement from the pension or retirement source dated within the past three (3) months prior to the application date.
  Alternative documentation: The most recent annual statement
- ***Social Security (SSDI/SSI) benefits:***
  Preferred documentation: Award letter for the current year.
  Alternative documentation: Letter from SSA dated within the past three (3) months prior to the application date.
- **Unemployment benefits**
- **Child support**
- **Alimony**
- **Survivor benefits**
- **Interest and/or dividend income**
- **Income from annuities**
- **Gambling winnings**
- *Student loans are not income so they are not reported*

6. Client Choice

The HSP network is designed to improve health outcomes for persons living with HIV by ensuring that they have access to services that reduce barriers and help them remain in care. Maximizing client choice and ensuring their autonomy allows individuals to find a mix of services that best meets their needs.

Clients must be enrolled with one and only one HSP agency as their primary provider, where they receive Medical and/or Non-Medical Case Management. This ensures that there is not duplication and that each client has a single care plan to fulfill their needs and reduce barriers to care. However, to ensure client choice and access to all needed services, other than Medical and Non-Medical Case Management, clients may receive other medical or support services from other HSP agencies or other program contractors via referral from their primary HSP.

Each HSP agency funded by the NMDOH HIV Services Program must ensure and document client choice. This requirement is also found in each provider agreement and will be reviewed for compliance during administrative and fiscal site visits by the NMDOH HIV Services Program.

All HSP organizations that provide case management services and enroll clients into the HSP network must comply with the following policies. If the organization provides directly or under its parent/umbrella organization any of the following services, clients must be informed that they may elect to receive these services directly from the organization or from any outside provider.

- Ambulatory medical care
- Dental services
- Pharmacy consultation and/or dispensing services

- The organization must inform clients that this decision will not impact their ability to receive case management or enrollment assistance from the HSP organization.
- The organization must not exclude clients from any services they provide to all eligible clients living with HIV if they elect to secure any of these services from an external organization or provider.
- Ensure that all clients complete a *"HIV Services and Enrollment Choice Form"* at least once per calendar year, normally upon enrollment or re-enrollment in the HSP network. This form will be retained in the client's files for at least three years.
- If the organization offers pharmacy consultation and/or dispensing services under parent/umbrella organization, the *"HIV Services and Enrollment Choice Form"* must, at a minimum, include the following language.
  "Our organization supports every patient's right to select a pharmacy that best meets and suits their needs. We will gladly submit prescriptions or make referrals to any pharmacy of your choice. This choice will not impact any other services you receive."
- If the organization offers ambulatory medical care and/or dental services under parent/umbrella organization, the *"HIV Services and Enrollment Choice Form"* must, at a minimum, include the following language.
  "Our organization supports every patient's right to select a medical provider and a dental provider that best meets and suits their needs. We will gladly make referrals to providers that

participate in the HIV Service Provider (HSP) network and outside providers that accept your insurance. This choice will not impact any other services you receive including case management and assistance in enrollment in the HSP network."

- All communications with clients must be consistent with the policy of client choice and not coercive in any fashion to encourage one option over another. It is appropriate to explain differences in benefits, such as which organizations are and are not preferred providers of various health insurance plans.

7. Client Incidents, Suspension, and Termination

All HSP network agencies must provide the full range of available and funded services to any eligible client, based on the needs of that individual. Eligible clients may not be refused service.

In the event that a client is determined to be a threat to the safety of agency staff or other clients, services may be suspended for cause for up to 30 days. Safety can be incidents or prolonged duration of verbal abuse or harassment, physical violence or a threat to commit, property damage, etc. Any incident identified as a safety issue must be documented and sent to the Program Manager/Section Manager within 72 hours of the incident. Suspension may include solely excluding in-person visits to agency facilities or it may include suspension of service provision. The organization must inform the NMDOH HIV Services Program Manager of this decision. Arrangements must be made to ensure that there is no gap in access to ambulatory medical care or HIV-related medications during this suspension.

Termination of a client from having access to services provided by an agency is a more significant step. In this case, documentation of a threat to safety must be confirmed with a contact to law enforcement or criminal justice. This could be via a police report, request for restraining order, contact with the appropriate government agency (i.e. adult protective services) or a similar official action. While assuring safety of agency staff and other personnel, there should be an effort to connect the individual with other services to avoid a lapse in medical care. These efforts should be documented in the client files to show that there was work to ensure ongoing care. Within 72 hours of this termination, the organization must inform the NMDOH HIV Services Program Manager of this decision and the medical provider(s) to which the client was referred to avoid any service gaps.

A single file containing documentation of all client incidences, suspensions and terminations must be maintained at the agency. All documentation in this file shall be retained for at least three years from the action. This requirement will be reviewed for compliance during administrative and fiscal site visits.

Due to the sensitive nature of this information, it should be maintained confidentially and securely. Only staff with a significant reason to have access should be able to review this documentation. HSP's must have policies and procedures in place to address staff and client safety and crisis management.

8. Service Categories and Standards of Care

Services provided as part of the HSP network are eligibility programs and not entitlement programs such as Medicaid and Medicare. Therefore, the services provided by the HSP agencies are subject to accessibility, availability, and funding statewide. This means there may be some services which are not provided in a Public Health Region or specific HSP office but are available elsewhere in the state.

The following services are or can be funded in the HSP network, depending on availability of resources and need.

- ***Core medical services*** include outpatient and ambulatory health services (OAHS), AIDS Drug Assistance Program (ADAP), Dental Assistance Program (DAP), early intervention services (EIS), health insurance premium (HIP) and cost-sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, substance abuse outpatient services, and medical case management, including treatment-adherence services.
- ***Support services*** must be linked to medical outcomes and may include medical transportation, linguistic services, psychosocial support services, non-medical case management, housing services, emergency financial assistance, behavioral health and substance use, and food bank services.
- As a recipient of funds under Part B of Ryan White, the NMDOH HIV Services Program must ensure that at least 75% of total federal dollars are expended for core medical services and no more than 25% on support services.

Ryan White legislation and policy define the allowable uses of these federal funds. Definitions of all the service categories noted above can be found in HRSA's policy clarification notice (PCN) number 16-02 revised 10/22/2018. This can be found at:
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf

In addition to HRSA definitions of service categories, more specific guidance on delivery can be found in the NMDOH HIV Services Program's *Standards of Care*. The Program's *Standards of Care* are reviewed and revised every 2 years. This process will include input from HSP's, clients and stakeholders. Areas addressed will include adding, removing, or revising services, personnel qualifications, service standards, measures, and outcomes.

Where these standards have been established, HSP and other HIV contractor organizations must deliver services in a fashion that substantially complies with them. Failure to do so may result in requests for reimbursement being denied as non-compliant. The *Standards of Care* is the guidance document to annual sub-recipient chart audits. Chart audits are completed using the standards of each service to grade an HSP on the quality and efficacy of providing equitable care. Each area of audit is identified in the standard with a measure and completion percentage.

9. AIDS Drug Assistance Program (ADAP) Services

The NMDOH HIV Services Program administers the state's AIDS Drug Assistance Program (ADAP). To ensure that the program is cost effective and serves those in need, New Mexico's ADAP includes a variety of services described below ranging from direct dispensing of medications to support for medical insurance premiums that include prescription coverage.

New Mexico's ADAP is funded entirely with specific federal dollars that are earmarked for this purpose as part of the Part B award under Ryan White. Because this program is entirely supported with federal resources, the HRSA definition of ADAP is key to understanding this activity and providing services in a way that complies with federal policies.

> ***The AIDS Drug Assistance Program (ADAP) is a state and territory-administered program authorized under Part B that provides FDA-approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare. ADAP funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments.***
>
> ***Ryan White legislation requires that each ADAP must cover at least one drug from each class of HIV antiretroviral medications on their ADAP Formulary. These funds may only be used to purchase FDA-approved medications.***

Each funded state must determine its own list of medications that will be provided within the ADAP. This list is known as the state's "ADAP Formulary". In New Mexico, the formulary is determined by an ADAP Medical Advisory Committee that is convened by the NMDOH HIV Services Program. This committee has extensive expertise among its members including physicians and pharmacists with training in HIV care.

The New Mexico Formulary currently no longer has a specific list of medications that are included in a standardized "formulary". Instead, the state uses an Enhanced Formulary model. Under this model, any FDA-approved medications could be considered for coverage depending on the patient's needs, prescriber's recommendations, and specific health insurance coverage.

Prescribing and treating physicians and other clinicians must be licensed to practice in the State of New Mexico. Prescriptions from out of state physicians will not be accepted either for payment of co-pays, co-insurance, or deductibles or for filling prescriptions directly by the state pharmacy. This can be reviewed on a case-by-case basis for Bridge fills.

Any out of state prescriptions will be referred back to the patient and their provider. Medications from the state pharmacy will not be delivered to an address outside of New Mexico. Medical services delivered by out of state medical providers are not eligible for reimbursement.

ADAP will not cover the cost to replace drugs or other items that have been lost, stolen, destroyed, or misplaced. Individual health insurance plans supported via IAP may elect to offer such replacement or not, at their discretion.

ADAP Bridge Program

ADAP Bridge Program is a service for persons who are eligible and enrolled in New Mexico's ADAP. It is designed as a short-term solution to get clients their medications quickly while they await insurance coverage. ADAP Bridge provides medications directly from the state's contract pharmacy.

Pre-insurance medication access is provided to any fully enrolled client or client in the process of enrolling in the HSP network and ADAP whose insurance coverage for prescription drugs is delayed. Most often this time period will be for 30 days or less, as most prescription coverage starts the 1st of the month following the insurance application acceptance and approval for coverage. ADAP Bridge coverage will provide required HIV related medications during this delay.

On approval of ADAP Bridge, any medications on the ADAP Formulary for which the client has a valid prescription may be filled. ADAP Bridge will only provide up to a 30-day supply.

ADAP Bridge is designed to be a short-term option, normally to fill medications for one 30-day period. In the case that efforts have been made to secure other sources of medication and/or health insurance coverage but these are not in place at the end of the thirty days, a request may be submitted for an exception to provide an additional 30 days. Only two such extensions can be granted for a client in each state fiscal year.

The ADAP Bridge program is the costliest way to access medications. Therefore, extensions will be granted rarely and only be for unique circumstances where there is an emergency that may lead to a gap in medication access. It must be shown that this emergency occurred as insurance or other coverage was delayed despite sincere and significant efforts. Exceptions for extensions can only be granted by the HIV Services Program Manager or HIV, STD, and Hepatitis Section Manager. Persons who have prescriptive insurance coverage will not be granted coverage under the ADAP Bridge.

Insurance Assistance Program (IAP) for Insurance Premiums

The Insurance Assistance Program (IAP) is designed to help persons with HIV access their medications by supporting health insurance premiums. That includes commercial plans, private plans available via the Affordable Care Act (ACA) Marketplace and the New Mexico Medical Insurance Pool (NMMIP) high risk pool. *(As NMMIP is a unique option, it is discussed in the following section.)*

For a health/medical insurance plan to be eligible for payment of premiums via IAP, it must provide HIV and HIV-related medications. IAP covers medical and other prescription insurance only. It does not pay for dental, vision or discount plans.

Any organization funded by the NMDOH HIV Services Program specifically to deliver IAP services may pay health insurance premiums for eligible and enrolled clients. This does not include premiums for NMMIP coverage, as such costs are paid directly by NMDOH.

IAP can cover the client's share of employer health insurance if there is a documented need. This does not include costs other than medical insurance, such as dental or vision plans. It also does not include the full cost of insurance for a family unit, but rather just the portion of the premium to insure the client. Since Ryan White does not allow direct payments to clients, individuals cannot pay their premiums (either by direct payment or payroll deduction) and be reimbursed. IAP must pay the

premiums directly, either to the employer or insurance carrier, so that these costs will not be deducted from the employee's paycheck.

For payment of health insurance premiums by IAP, clients must select insurance option that is among those recommended by the NMDOH HIV Services Program and these policies. If there are multiple choices for which the client is eligible, they must choose the lowest cost option (i.e., Medicaid vs. employer-based insurance).

New Mexico Medicaid Portal: https://nmmedicaid.portal.conduent.com/static/index.htm

Be Well NM Health Insurance Exchange: https://www.bewellnm.com/

IAP and ACA Marketplace Plans

The private health insurance "Marketplace" under the Affordable Care Act (ACA) allows enrollment both during an annual open enrollment window and when a client has special circumstances that trigger a special enrollment. These closed time periods are important opportunities to secure cost-effective health insurance for clients.

Prior to each year's open enrollment window that occurs in the late fall, the NMDOH HIV Services Program will analyze health insurance plans that will be available on the ACA Marketplace for the following year. Based on an analysis of cost and benefit, some plans will be recommended while others will be deemed ineligible. For payment of health insurance premiums by IAP, clients must select an insurance option that is among those recommended by the NMDOH HIV Services Program.

Various plans can have significant differences in costs to be borne by the client and/or reimbursed via IAP. For example, insurance options that cover a percentage of the cost of prescriptions rather than having a fixed-dollar co-pay amount are likely to be much more expensive due to the high cost of HIV-related medications. Plans with specialty drug co-insurance costs greater than 20% of the total medication cost are unlikely to be included among the recommended options, unless this cost has a modest cap based on cost-sharing required under ACA. Plans may also be costlier if the client's providers are out-of-network.

Clients should be provided with information prior to enrollment that helps them to make a free and informed choice. Case managers at HSP network agencies should provide information without bias for any plan or carrier. Clients should be informed that plans that are not recommended by the NMDOH HIV Services Program are available to them but will not have premiums covered via IAP.

Factors that should be explained while offering patient education include: 1) whether each plan has the client's primary HIV care provider as an in-network provider, 2) whether each plan includes the client's HIV and other ADAP formulary medications as a covered option and at which "tier" of coverage, 3) the potential cost to the HIV Services Program to cover co-pays, deductibles and out-of-pocket costs for medical visits and formulary medications, and 4) the potential out-of-pocket cost to the client for services for which reimbursement is not provided. It is also helpful to review the client's other medical conditions and their potential costs under various plans, particularly as many of these will be borne directly by the client rather than by IAP.

Case managers should provide information about plans at various "metal" levels on the Marketplace, so that clients can pick a plan that fits their needs and meets this program guidance.

- For premiums to be paid by IAP, clients should pick a plan from either the “Silver” or “Gold” level. Plans below the Silver level do not have adequate federal cost sharing and plans above Gold (i.e., “Platinum”) have premiums that are too costly.
- For persons with household income below 250% of the Federal Poverty Level (FPL), a Silver plan has the best cost sharing and should always be the choice.
- ***For persons with household income below 250% of the Federal Poverty Level (FPL), a Silver plan usually has the best cost sharing and should almost always be the choice. Gold level plans will be considered if it is shown to be cost effective.***
- For persons with household income between 250% and 400% of FPL, Silver plans are typically best but a Gold plan may be chosen if it’s shown to be cost effective.

Once an ACA Marketplace plan has been selected and enrollment via the website or an insurance broker is complete, the case manager must submit information to the NMDOH ADAP Coordinator before IAP can pay for premiums. This Marketplace plan update information must include, at minimum, the carrier, plan name, start date, monthly premium cost, Premium Tax Credit (PTC) amount, and the summary of benefits including information about prescription coverage.

When a client transfers to a new health insurance option away from NMMIP or an ACA Marketplace plan, HSP network agencies are required to notify and submit a closure request to the NMDOH ADAP Coordinator within five (5) working days of the date of enrollment in a new health insurance coverage option. This is essential for clients receiving IAP assistance with premiums, to avoid duplicate and excess payments. It is also required for clients previously enrolled in NMMIP who move to another coverage option. For those clients, both the HSP network agency and NMDOH will inform NMMIP to remove this client from their coverage and billing with the soonest possible effective date.

Continuous insurance coverage with no lapses is essential. Any gap in insurance can hinder access to medical care and medications. Also, because lapses will typically not trigger special enrollment, a client may be without insurance for an extended period of time. This will greatly increase the cost of medical care and medications. The HSP network agency that enrolled the client is responsible for ensuring that updated information is provided to the NMDOH HIV Services Program and the organization making premium payments via IAP to ensure timely and accurate payments. This includes any changes to the insurance plan, premium cost, payee or address.

Any lapse in coverage due to this information not being provided or not submitted in a timely fashion can increase costs to the NMDOH HIV Services Program. The program reserves the right to shift these excess expenses to the HSP network agency by deducting them from future invoices.

Under circumstances where a client’s ADAP enrollment has lapsed or that premium payments were missing or delayed causing a gap in IAP, loss of insurance and/or back premiums that are due, the case manager is to contact the ADAP Coordinator and provide the following information.

- Client’s current HSP network and ADAP enrollment status (i.e. active, lapsed or closed).
- Status and timeline of completion and submission of re-enrollment or recertification application and supporting documentation.

- Information about back premiums due including the specific months that are unpaid and total balance due. This should be verified by contacting the insurance carrier.
- Whether the carrier will accept late payments and reinstate insurance, and whether there is a deadline to do so.
- HIV medications currently prescribed to client.
- Case manager's recommendation for ensuring access to medications (i.e., Bridge or paying back premiums).
- Availability of other funding sources to assist the client in gaining access to medications. This should include any cost-sharing that the HSP network agency can provide using other funding sources.

Using this information, the NMDOH HIV Services Program will determine the most cost-effective option for the individual client. This may include: 1) approving ADAP Bridge services for formulary medications until the insurance can be re-instated, 2) payment of back premiums that are due for any months when the client was enrolled in ADAP, and/or 3) utilization of Patient Assistance Programs or other sources until insurance resumes.

ACA Marketplace plans have modest premiums because the law provides for cost sharing and Premium Tax Credits. These are based on various factors, particularly income. It is important to maximize these credits for two reasons: 1) this reduces the premium to be supported by IAP, and 2) this avoids having a client receive a tax refund due to not maximizing the credit when premiums were paid. Two important tasks are necessary to secure the largest possible credit.

- All clients enrolling in ACA Marketplace plans must select ADVANCE Premium Tax Credits. This means that the credits are taken off the cost of each monthly premium when due. IAP will not pay premiums for any client who does not select to have the credits in advance.
- All clients with ACA Marketplace plans must update the financial information when it changes significantly, either with an increase or decrease. This will cause the credits to be adjusted during the course of the year. If this does not happen, the credits will be adjusted only when federal income taxes are filed for the year.

It is essential to avoid adjustments to the Premium Tax Credits at the time of tax filing. If an error or lack of financial update meant that the credits were over-stated, the client may end up owing money back to the federal government. IAP cannot support payment of taxes, so the client may be left with a large and unanticipated expense. If an error or lack of financial update meant that the credits were under-stated or not claimed in advance, the client will get them with the tax return. This can either reduce the amount they owe or increase their refund. Given that these funds were based on prior premium payments by IAP, the client must refund these amounts to IAP. Calculating the correct amount and securing payment from the client are likely to be challenging, so this situation should be avoided.

Notifying the Marketplace about changes in circumstances as soon as they occur will allow the Marketplace to update the information used to determine the expected amount of the Premium Tax Credit and adjust the advance payment amount. This adjustment will decrease the likelihood of a

significant difference between the advance credit payments and the actual Premium Tax Credit. Changes in circumstances that can affect the amount of the actual Premium Tax Credit include:

- Increases or decreases in household income, including lump sum payments like a lump sum payment of Social Security benefits or taxable distributions from an individual retirement account or other retirement arrangement
- Marriage
- Divorce
- Birth or adoption of a child
- Other changes to household composition
- Gaining or losing eligibility for government sponsored or employer sponsored health care coverage
- Moving to another address

Additional information about the Premium Tax Credit can be found on the IRS website at: https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit

In cases where these steps are not followed and the client become eligible for funds via the Premium Tax Credit at the time of federal tax filing, these dollars must be recouped. Per Ryan White regulations and policies, HSP network agencies are expected to vigorously pursue repayment of these funds by the client.

Repayment must be as follows, with agencies vigorously pursuing one option:

- Submitting payment via check, money order or cash to the HSP network agency in the full amount of the refund of Premium Tax Credit overpayment within six (6) months of receiving the tax refund.
- Establishing a repayment plan with the HSP network agency that will complete full repayment within six (6) months of receiving the tax refund.

Anyone who receives a Premium Tax Credit must file a federal tax return for the year in which the credit was awarded. This is done to reconcile actual income over the year, which may adjust the final amount of the credit. The requirement to file federal tax returns is from the Internal Revenue Service (IRS), not a policy of Ryan White or NMDOH.

To document excess payments were not made by IAP, all clients enrolled in an ACA Marketplace plan for any part of the year must submit part of their federal tax filing to their case manager. These documents are required at HIX updates

- Form 1040 (without schedules)
- Form 1095-A: Health Insurance Marketplace Statement
- Form 8962: Premium Tax Credit (PTC)

On Form 1040, line 46 indicates excess Premium Tax Credits and the amount owed. Line 69 indicates the net Premium Tax Credit owed to the client and amount of associated refund.

Note: As of April 1, 2017, NMDOH no longer has a sliding scale for payment of health insurance premiums for Marketplace plans according to household income. The guidelines to pay 80%, 90% or 100% of the premium based on income levels no longer apply. The NMDOH HIV Services Program will reimburse agencies funded to provide IAP for 100% of premiums paid for eligible clients.

New Mexico Medical Insurance Pool (NMMIP)

The New Mexico Medical Insurance Pool (NMMIP) is a high-risk insurance pool that serves persons who are ineligible for other insurance options. Prior to implementation of the ACA, most persons living with HIV in the state had insurance from NMMIP, as they were excluded from other insurance due to HIV being a "pre-existing condition". NMMIP now insures fewer PLWH, as many are eligible for expanded Medicaid coverage or private insurance purchased via the ACA "Marketplace".

NMMIP will provide insurance only to persons who are ineligible for other options. Applications for this pool require documentation of attempts to secure Medicaid, other public insurance, and/or private insurance options. Such standards and requirements are established by NMMIP. Case managers must comply with these guidelines to secure approval and coverage.

If a client with NMMIP coverage becomes eligible for other insurance, the HSP network agency must inform the NMDOH HIV Services Program and the NMMIP administrative offices. This request must note that the client has new insurance coverage, note the start date of this coverage, and request disenrollment from NMMIP. This must be done within five (5) working days of the start date of the new coverage, to avoid duplicate payment of premiums. If there are duplicate payments for insurance due to delayed notification from the HSP network agency, these excess costs may be imposed on the agency by deducting these amounts from future invoices.

NMMIP has its own guidelines about client eligibility. For individuals who apply for NMMIP due to missing other insurance options such as open enrollment for the ACA Marketplace or employer-sponsored insurance, NMMIP will only approve coverage for the balance of the calendar year. If these opportunities are missed again in the following year, IAP will not cover NMMIP premiums even if the client is approved for coverage.

All clients enrolled in AIDS Drug Assistance Program/Insurance Assistance Program (ADAP/IAP) and requesting premium assistance must maintain their ADAP/IAP enrollment by submitting yearly the required documents in to e2NM within 15 days of due date. A client who is enrolled in New Mexico Medical Insurance Pool (NMMIP) and experiences a lapse in ADAP/IAP enrollment will be provided a 30-day grace period to re-enroll before the ADAP/IAP program will terminate NMMIP insurance premium payments. A 60-day extension may be granted in cases of a legitimate extenuating circumstance. To request a 60-day extension, case management is required submit a justification via secure e-mail to the ADAP Coordinator detailing the extenuating circumstance before the 30-day grace period is over. The ADAP coordinator will evaluate the justification and notify case management of the approval or denial of the request for extension within 5 business days. If a client fails to re-enroll and the ADAP/IAP program terminates premium payments, the case manager has 5 business days to notify both NMMIP and the ADAP/IAP program of the client's termination of coverage or request to be moved to self-pay. If a client is moved to self-pay, both the client and case management site will be responsible for their NMMIP premium payments. Per NMMIP policy (Section 7)

https://secureservercdn.net/166.62.112.193/241.40d.myftpupload.com/wp-content/uploads/2017/12/CLEAN-COPY_NMMIP_EPO-PLAN_PPO0001_1.2018-sm-12.20.17-002.pdf) if a client is *voluntarily terminated from NMMIP they are subject to a 12-month exclusion period before they are eligible to reapply for NMMIP coverage. If a client has been granted NMMIP coverage before the 12-month exclusion period is complete, the case manager must provide the ADAP/IAP program written proof that they client is current on their NMMIP premium payments before they will be eligible for NMMIP premium assistance. The ADAP/IAP program is not responsible for past due premiums for periods of time that a client was not enrolled.

State Pharmacy

The state pharmacy is the ADAP-specific pharmacy operation that is fully supported by the NMDOH HIV Services Program. At the current time, the state pharmacy is operated by Southwest CARE Center via a contractual relationship with NMDOH

The state pharmacy is the only source that can provide all medications under the ADAP Bridge program. These prescriptions cannot be filled by any other pharmacy. This is designed to be both cost-effective and rapid in delivering medications so there is no gap in treatment.

Any client who receives health insurance premium assistance via IAP may elect to fill their prescriptions at the state pharmacy. This source can serve any IAP clients, including persons with NMMIP insurance.

Prior to directing a client to contact the state pharmacy to dispense medications, case managers should confirm that the client is actively enrolled in ADAP. In addition, ADAP Bridge requests must be approved by the NMDOH ADAP Coordinator or HIV Services Program Manager prior to requests any medication to be dispensed.

IAP Payment of Medication Co-Pays, Co-Insurance and Deductibles

Any organization funded by the NMDOH HIV Services Program specifically to deliver IAP services may pay medication co-pays, co-insurance and/or deductibles for medications if they are specifically included on the state's ADAP Formulary. Such payments are only for eligible and enrolled clients.

Clients receiving IAP services are encouraged to use the state pharmacy for dispensing and consultation regarding ADAP Formulary medications. This pharmacy has expertise in HIV-related medications and care. In addition, dispensing of medications by this pharmacy to persons with health insurance coverage generates income. These funds return to the NMDOH HIV Services Program as program revenue that supports services for persons living with HIV (PLWH) across the state.

Organizations funded to deliver IAP may not bill the NMDOH HIV Services Program for medication co-pays, co-insurance and/or deductibles for any pharmacy activity that does not utilize the state pharmacy. Such costs may be borne directly by the funded agency or pharmacy.

This requirement to use the state pharmacy to seek IAP reimbursement is waived in a specific situation. If the client's insurance uses a closed pharmacy network that does not include the state pharmacy and/or if this insurance does not allow access to this pharmacy, the client may use an option that is within their insurance network. In that case, payment of co-pays, co-insurance and/or deductibles by an agency funded by IAP will be reimbursed by the NMDOH HIV Services Program. Prior to such reimbursement by IAP, the client's case manager must seek and get approval from the

NMDOH ADAP Coordinator for a waiver by justifying that the insurance carrier has a closed pharmacy network.

10. AIDS Drug Assistance Program (ADAP) Enrollment and Eligibility

All persons must be eligible for and actively enrolled in the HSP network to receive ADAP services. Clients must be enrolled in and utilizing Medical Case Management, to ensure coordination between ADAP services and ambulatory medical care so that the client is prescribed, and accesses needed medications.

There are additional eligibility criteria that apply to become eligible for ADAP in addition to HSP network enrollment. Some specific ADAP services, such as ADAP Bridge and the Insurance Assistance Program (IAP), have additional eligibility and/or documentation requirements. These are described in the following sections.

Enrollment requirements should not delay or serve as a barrier to accessing medications. Some services are particularly time sensitive, such as securing medications via the ADAP Bridge program for newly diagnosed individuals or those newly reconnected to care.

e2NM is designed to provide rapid enrollment for PLWH who are newly diagnosed or need to be reconnected to care. Case managers enter all the necessary information in to e2NM with the client to determine eligibility. This process takes no longer than 5 minutes. Clients who are unable to provide the required document(s) (HIV status, proof of residency, proof of income, insurance information) at the time of intake can work with the case manager to set a time when the documents will be available. Case managers contact their agency Liaison to inform them of the new enrollment and if needed, an extension to submit the clients' documents. e2NM will automatically determine eligibility and notify the case manager in real time of the client's enrollment status. This process allows for the immediate provision of core medical and support services for the client.

In such cases, enrollment can be expedited to avoid any gaps in medication access. The following steps should be followed for expedited approval in such cases. Applications for ADAP and the ADAP Bridge can be submitted directly to the NMDOH ADAP Coordinator.

ADAP enrollment should be expedited for clients who have recently been discharged from the hospital. This would be for persons who were taking or prescribed antiretroviral medications and/or medications for treatment of an opportunistic infection at the time of discharge. To avoid having a drug regimen interrupted, enrollment can be completed even if required documentation of all income sources cannot be provided immediately. Enrollment will be approved based on self-reported total household income, with up to five working days allowed to provide such documentation. If no medications were provided or prescribed at the time of discharge, this expedited process is not needed and does not apply.

Eligibility for all ADAP services requires the following additional documentation, in addition to information provided for HSP network enrollment. All required documentation and additional documents requested by the ADAP Coordinator must be entered into the e2NM Document Tracker located in the Intake tab. The ADAP Coordinator will review uploaded documents for correctness and make the final eligibility determination.

- Documentation of any current health insurance that the client has in effect.
- Information about any other health insurance options for which the client is eligible, including insurance provided by an employer or available for their family unit due to eligibility of their spouse or a dependent.
- Documentation that an application has been made and submitted for health insurance coverage, if eligible for Medicaid or ACA Marketplace plans.
- Some plans require documentation of whether or not the client uses tobacco products to avoid a premium surcharge. If this is required, the information must be completed and submitted in a timely fashion to avoid excess cost.

The following documentation requirements are specific for IAP services.

- A copy of client's insurance card. Also, a copy of the prescription benefit card, if separate.
- Summary of Benefits from client's insurance company detailing both medical and prescription benefits and costs.
- Documentation of insurance premiums, including the amounts, due dates, payee and other relevant information, if seeking IAP coverage of premiums.
- For IAP coverage of ACA Marketplace plans, additional information from the ACA enrollment is also required. This includes documentation from the Marketplace website or insurance carrier clearly stating the monthly premium, the amount of the Advanced Premium Tax Credit (APTC)/ Federal Health Insurance Subsidy, the selected plan's deductible and out-of-pocket maximum, the client's annual income as calculated by the Marketplace website, the name of the insurance carrier, and the exact name of the insurance plan selected.

The following documentation requirements are specific for the ADAP Bridge program.

- ADAP Bridge services require that the client has a valid prescription for at least one medication that is included on the state's ADAP Formulary.
- ADAP Bridge is designed to be a short-term option, normally to fill HIV-related medications for one thirty (30) day period. Documentation of efforts to secure ongoing sources of medication and/or insurance coverage is normally required before an ADAP Bridge request is approved.
- A complete list of all current prescription medications being taken by the client may be requested.

ADAP Bridge is the last option for emergency situations. Persons are not eligible for ADAP Bridge in any of the following circumstances.

- The individual is eligible for and enrolled in any third-party insurance option that will provide HIV related medication, regardless of the cost to fill medications.
- The ADAP Bridge is the most expensive option and the payer of last resort. The case manager must provide proof that other services to assist with obtaining medications have been applied for and/or utilized (i.e., Patient Assistance Programs) or proof that an application for

insurance coverage has been submitted and is awaiting approval (i.e., NMMIP or COBRA). ADAP Bridge may be denied due to inadequate documentation.

- Clients with Medicare Part D coverage are not eligible for ADAP Bridge. Case managers are advised to enroll Medicare clients who are also not eligible for Medicare "extra-help" in IAP and the NMMIP Carve-Out plan before they reach the gap (or "donut hole") in their Part D medication coverage.
- Because Medicare clients over the age of 65 are not eligible for NMMIP Carve-Out coverage, ADAP Bridge can be used. Once those individuals reach the gap (or "donut hole") in their Part D medication coverage, case managers should contact the NMDOH ADAP Coordinator to apply for ADAP Bridge support. This can be used until they are no longer in the medication gap or have enrolled in another Part D plan for prescription coverage.
- Persons with Medicaid coverage are not eligible for ADAP Bridge.

Clients who are dis-enrolled from the HSP network will also become inactive and dis-enrolled from ADAP services. Individuals may also be dis-enrolled specifically from ADAP for several reasons:

- The client fails to provide a current address within 5 days of enrollment in e2NM.
- The client voluntarily declines other available insurance options. These include employer-based insurance or coverage through a spouse's insurance program when such an option is available. Declining such coverage without pre-approval by the ADAP Coordinator can be cause for disenrollment.

Services will not be discontinued or interrupted when doing so would pose a significant risk of harm to the client, such as in the following situations:

- Discontinuation or interruption in service constitutes an immediate risk to the pregnant client's unborn child.
- A deadline was missed because of physician-documented health issues (i.e., client is hospitalized or is too ill to respond to complete re-enrollment forms). The patient's case manager may be asked to assist in verifying physician-documented health issues and the circumstances surrounding the event.
- A deadline was missed because of a documented catastrophe or "act of God" (i.e., client's house burns down, or client is delayed while traveling because of inclement weather). Proof of this catastrophe must be provided.
- The client had or has a mental health episode or impairment documented by a medical or mental health care provider (i.e., client experienced a psychotic break and was incapable of completing the requested task, or client's partner/immediate family member died 30 days prior to re-enrollment and was incapable of responding). The patient's case manager may be asked to assist in verifying provider-documented health issues and the circumstances surrounding the event.
- The client performed as required, however staff from the HSP network agency failed to meet the deadline (i.e., client's HIV case manager received requested papers from client but failed

to mail them to NMDOH by the deadline). This exception must include a written explanation signed by a manager or supervisor with authority over the case management program.

Ryan White policies and regulations have restrictions on providing services and medications to persons who are incarcerated, in some circumstances. These depend on factors such as the length of the sentence, time until release, type of facility, and whether the facility has a legal mandate to provide medical services including prescriptions. To ensure that guidelines are followed without posing unnecessary barriers to continuity of care, case managers should seek guidance from the NMDOH ADAP Coordinator if a client is incarcerated and in need of medication

The highest priority for ADAP is to ensure clients have access to medications. Therefore, timely enrollment to ensure no gaps in coverage are essential to meet this priority. The ADAP Coordinator and other HIV Services Program staff will monitor the timeliness of enrollments in the program under the Clinical Quality Management (CQM) Program. Performance that falls below 80% re-enrolled with no gaps will be reported to providers so that the individual organizations can identify any issues with policies or practices that result in delayed or late re-enrollment.

11. Client Transfers among HSP Network Providers

Eligible clients may only be enrolled with one HSP network agency at a time. This organization is responsible for timely enrollment. Only this primary HSP network agency may provide Medical Case Management to the individual. This is to avoid duplication.

The HSP at which the client is enrolled coordinates the client's individualized care plan, including making referrals for needed services. They are referred to as the Primary. Per *Section 6: Client Choice*, enrolled clients may choose to receive services from the Primary HSP or they may elect to use other another HSP which provides support services that the Primary does not such as: Behavioral Health/ Substance Use, Social Support groups, Food Bank, Housing Specialist services, Harm Reduction and/or Syringe Exchange. This includes other HSP network agencies that offer a range of services and external providers not supported by the NMDOH HIV Services Program, Harm Reduction, Syringe Exchange, Overdose Prevention and PREP for partner services.. Having a single HSP network agency responsible for enrollment and the care plan ensures that there are no gaps in services or duplication.

An enrolled client may choose to transfer to another HSP network agency to be their primary site for enrollment and care plan coordination. This process involves documenting the client's choice. The HSP network agency that previously served the individual should ensure that linkage has occurred before closing the client's file. In addition, the organization cannot deny this individual's access to any other services supported by the NMDOH HIV Services Program except for case management.

A case manager at either the referring or receiving HSP network agency can assist the individual in completing a transfer form. This form must be signed by the client (or their legal guardian) to document their choice. Forms are then submitted to the HIV Linkage to Care Coordinator in the NMDOH HIV Services Program to review and confirm the transfer. Clients with questions about transfers should be given information to contact the HIV Linkage to Care Coordinator directly.

Enrolled clients may only elect to transfer HSP network agencies once per calendar year. Individuals who perceive a need to shift more than once should communicate directly with the HIV Linkage to

Care Coordinator about this request. If this staff member recommends additional transfers, this must be approved by the NMDOH HIV Services Program Manager or HIV, STD and Hepatitis Section Manager.

12. Client Rights and Responsibilities

All persons enrolled in the HSP network should receive services that are high quality and follow best practices, without experiencing any discrimination or unnecessary barriers to care. To ensure such quality and access, all enrolled persons have the following **RIGHTS**:

- Be informed and receive written information about available services.
- Receive communication in a fashion that is accessible, including being spoken to in a language that is understood.
- Receive a complete explanation of program requirements, procedures, and standards.
- Be informed of the responsibilities as an HIV services recipient, including the need for timely enrollment and documentation required.
- Be treated with dignity and respect.
- Receive services for which you are eligible without discrimination due to race, color, national origin, religious affiliation, gender or gender identity, sexual orientation, age, or physical or mental disability.
- Have information to appropriate health care providers or payer sources only be shared with the client's signed permission, except as noted in HIPAA Privacy Policies.
- Request a review of any grievances or complaints regarding the delivery of services or treatment by any provider reviewed by the NMDOH HIV Services Program Manager and/or HIV, STD and Hepatitis Section Manager.

Persons living with HIV are encouraged to be actively involved in all decisions about their medical care and services, to ensure that services are appropriate and matched with their needs. All individuals enrolled in the HSP network must follow policies and provide information that is needed to ensure continued access to care. All enrolled persons have the following **RESPONSIBILITIES**:

- Provide all information and documentation necessary for enrollment and eligibility determination.
- Ensure that all information provided for enrollment is accurate and presented honestly to the best of their knowledge.
- Inform the program in a timely fashion of any changes that may impact eligibility for services. This includes providing updates about income, other financial information, residency, and insurance status. This can be done by communicating with a case manager or other HSP agency staff member.
- Treat providers with consideration and mutual respect.

- Refrain from abusive, threatening, or violent language and behaviors.
- Ensure that they provide information in a timely fashion for enrollment to avoid any lapses in eligibility.
- Request assistance when needed. Inform a case manager, clinician or other HSP agency staff member about barriers and challenges that can hinder retention in medical care or ability to take medications.

13. Grievances

All HIV Service Provider (HSP) agencies must have a grievance procedure that applies to their full range of services for persons living with HIV. Each agency may develop their own policies that fit their needs if they include at least the following.

- Policies and grievance submission forms, if any, must be provided to clients on a routine basis. Normally this will be at least annually. A suggested practice is to provide a copy during the annual enrollment into the HSP network. It is also a good idea to document that policies and forms were provided, such as by making a notation in the client's files and/or having the client sign that they received copies.
- Grievance policies should be posted in client service areas in a way that is visible and seen by most clients. A suggested practice is to post a copy in each client waiting area. In addition, it would be helpful to post a copy in each room where clients see their providers or case managers.
- Grievance policies must allow for both verbal and written grievances to be submitted.
- All written grievances that are received should be stored in a single file. Within five (5) business days of receipt of any written grievance related to HIV care or support services, a copy shall be provided to the NMDOH HIV Services Program Manager and/or this position shall be notified of receipt of the grievance with a summary of key issues.
- Grievance procedures must specifically note that there will be no retaliation against clients for filling a verbal or written grievance. They also must clarify that clients will not be suspended or terminated from services based on filing of grievance(s).
- Grievance procedures must specify that a client who is unsatisfied with the outcome of the agency-specific grievance may contact NMDOH directly. All clients should be provided with contact information for the NMDOH HIV Services Program Manager and/or HIV, STD and Hepatitis Section Manager.

A single file containing documentation of all clients written grievances must be maintained at the agency. All documentation in this file shall be retained for at least three (3) years from the date of receipt of each written grievance. Both the file and this requirement will be reviewed for compliance during administrative and fiscal site visits.

14. Conduct and Conflict of Interest

Many people living with HIV (PLWH) and impacted by HIV are involved in delivering services to the community. Therefore, it is normal for PLWH and members of their family to serve as staff or Board of Directors members of HSP agencies or other HIV contractor organizations. These roles are not intrinsically a conflict of interest.

It is particularly important to assure privacy and confidentiality in these situations. While a PLWH involved as a staff or Board member may widely disclose their HIV status, receipt of services and other personal information should still be considered and treated as confidential.

A PLWH receiving services at an agency for which they work or serve as a Board of Directors member is eligible for the same services as any other individual, based on their income and other program criteria. Receipt of such services does not pose a conflict of interest.

A PLWH employed by an HSP agency or other HIV contractor organization cannot provide services to themselves, such as delivering case management or enrollment assistance. To ensure objectivity, it is preferable that they receive services from individuals with whom they don't work directly, whenever feasible.

No staff member may provide services directly to any member of their immediate family, member of their household, or any other individual who is financially dependent on or financially providing for this staff member. Such connections pose a conflict of interest which should be disclosed. An alternate staff requested to provide services if such a relationship exists.

15. Fiscal Management and Invoicing

The NMDOH HIV Services Program uses a contractual instrument known as a "Provider Agreement (PA)" for most of its funding relationships with medical and support services providers. The Provider Agreement is a special category of contract that is allowed by the state's procurement code under the "Health Care and Hospital Exemption". References to contracts below include any instruments that are Provider Agreements, as well as Professional Services Contracts (PSC) and other allowable forms.

All providers funded via such contractual agreements must submit invoices and reports on a regular basis. These must comply with all terms specified in the agreement as well as in these policies, including requirements about timeliness, accuracy and required documentation for each type of activity.

- All HIV Service Provider (HSP) agencies should invoice for services delivered during a given month by the 10th day of the following month, or the next business day if this falls on a weekend or holiday.
- All other HIV contractor organizations should invoice for services delivered during a given month by the 15th day of the following month, or the next business day if this falls on a weekend or holiday.
- Given state procedures for closing fiscal years, invoices for services delivered through June 30th in each year must be billed in a timely fashion at the start of July as directed by the

NMDOH HIV Services Program. Late or incomplete invoices not submitted by stated deadlines will not be payable in the current or future fiscal years.

- If information is incomplete on some services provided during the month, a partial invoice may be submitted. It is allowable to add other services to a supplemental invoice for the month, though it is preferable to add these billable units to a future month's invoice.
- The NMDOH HIV Services Program will often pay invoices that were submitted later than these deadlines, or that weren't submitted with full supporting information by the deadline. However, these will typically take longer for processing and payment.
- Per contractual language the NMDOH HIV Services Program reserves the right not to pay for services where invoices and reports were significantly delayed. Organizations should assume that payments will not be made for any services billed more than 45 days after the date of service.

Services may only be billed if they comply with the following guidelines.

- No HSP network agency or other HIV contractor organization may bill NMDOH for services in excess of the amount in their agreement for the current state fiscal year.
- No agency may bill for any service category for which contractual funds have been fully invoiced and exhausted. If there is a shortfall in a specific service category, the agency may submit a Budget Adjustment Request (BAR). The HIV Services Program will strive to review and respond to all BAR within five calendar days. All BAR's must be approved by either the HIV Services Program Manager or the HIV, STD and Hepatitis Section Manager. Only one BAR is allowed per agency per fiscal quarter.
- No HSP network agency or other HIV contractor organization may bill the NMDOH HIV Services Program for costs or expenses that are unallowable under federal Ryan White and sub-recipient monitoring legislation, rules and policies. This applies to all invoices and requests for payment, regardless of whether the utilize federal funds, including items billed to either state general fund (SGF) or program revenue dollars. All HSP network agencies should familiarize themselves with Ryan White rules and Policy Clarification Notices (PCN) 16-02 (Revised 10/22/18) PCN 16-02 RWHAP Services Eligible Individuals and Allowables Uses of Funds (hrsa.gov) to ensure compliance.
- All services offered by the HSP network will only be reimbursed by NMDOH if they are provided to persons living with HIV who are determined to be eligible. Services must be provided during the approved enrollment period.
- To determine the eligibility period, providers should look up enrollment dates for each individual in e2NM. The current enrollment period is listed in the Intake Information Tab under Eligibility. Past enrollment dates are located in the *Chart* link, under Eligibility in the Intake tab.
- All Ryan White service categories should be delivered in a fashion that complies with Ryan White legislation and policy. They should also be delivered in a way that complies with Standards of Care established by the HIV Services Program. Services delivered in a fashion that deviates from these guidelines may be denied for reimbursement.

- Ryan White funds must be used as a payer of last resort. For services such as ambulatory medical care and transportation that have other payers for many clients, case notes in e2NM and other documentation must demonstrate that no other payers were available or that all such resources were already exhausted or vigorously perused. SEE PCN 16-02 (PCN 16-02 RWHAP Services Eligible Individuals and Allowable Uses of Funds (hrsa.gov) for clarification

ADAP Program Insurance Premium
Assistance Invoicing Policy Update

ADAP Program New Mexico Medical Insurance Program (NMMIP)
Premium Payment Assistance Policy Update

Beginning, February 1st, 2020 the AIDS Drug Assistance Program will be modifying the monthly premium payment policies. ADAP will no longer accept case manager generated invoices as the sole form of invoicing for client's monthly premium payments. Please follow the updated policies below for ADAP premium assistance invoicing going forward.

HIX Plans

The ADAP program requires insurance company generated invoices no older than 30 days. If the most current insurance company generate invoice is not for the current premium payment month, in addition to the insurance company invoice, the case manager must attach a coversheet with client enrollment dates, amount the client is requesting to be paid, and the month that the premium payment is covering

Private Employer Insurance Plans

For clients on employer coverage that are requesting third party payments a yearly letter from the employer indicating monthly premium amount, payment address, and who the payment is to be made out to must be attached to a coversheet with client enrollment dates, amount the client is requesting to be paid, the month that the premium payment is covering, and a case manager signature indicating that they have confirmed that the client is still employed and eligible for insurance benefits with that employer.

Medicare Advantage (Part C) Plans

The ADAP program requires insurance company generated invoices no older than 30 days. If the most current insurance company generate invoice is not for the current premium payment month, in addition to the insurance company invoice, the case manager must attach a coversheet with client enrollment dates, amount the client is requesting to be paid, and the month that the premium payment is covering.

All clients enrolled in AIDS Drug Assistance Program/Insurance Assistance Program (ADAP/IAP) and requesting premium assistance must maintain their ADAP/IAP enrollment by submitting yearly certification. within 15 days of due date. A client who is enrolled in New Mexico Medical Insurance Pool (NMMIP) and experiences a lapse in ADAP/IAP enrollment will be provided a 30-day grace period to re-enroll before the ADAP/IAP program will terminate NMMIP insurance premium payments. A 60-day extension may be granted in cases of a legitimate extenuating circumstance. To request a 60-day extension, case management is required submit a justification via secure e-mail to the ADAP Coordinator detailing the extenuating circumstance before the 30-day grace period is over.

The ADAP coordinator will evaluate the justification and notify case management of the approval or denial of the request for extension within 5 business days of receiving the notification.

- This is 5 days to review a request of the extension of the grace period.
  If a client fails enroll and the ADAP/IAP program terminates premium payments, the case manager has 5 business days to notify both NMMIP and the ADAP/IAP program of the client's termination of coverage or request to be moved to self-pay. If a client is moved to self-pay, both the client and case management site will be responsible for their NMMIP premium payments.
- This 5 day period is to notify NMMIP of the clients IAP termination. If a client fails enroll and the ADAP/IAP program terminates premium payments, the case manager has 5 business days to notify NMMIP of the client's termination from the IAP program and to elect to move the client to self-pay or to terminate coverage. If a client is moved to self-pay, both the client and case management site will be responsible for their NMMIP premium payments.

Per NMMIP policy (Section 7 page 67) https://secureservercdn.net/166.62.112.193/241.40d.myftpupload.com/wp-content/uploads/2017/12/CLEAN-COPY_NMMIP_EPO-PLAN_PPO0001_1.2018-sm-12.20.17-002.pdf) if a client is *voluntarily terminated from NMMIP they are subject to a 12 month exclusion period before they are eligible to reapply for NMMIP coverage. If a client has been granted NMMIP coverage before the 12-month exclusion period is complete, the case manager must provide the ADAP/IAP program written proof that they client is current on their NMMIP premium payments before they will be eligible for NMMIP premium assistance. The ADAP/IAP program is not responsible for past due premiums for periods of time that a client was not enrolled.