| | |
|---|---|
| Local Service Category: | **Referral for Health Care: ADAP Enrollment Worker** |
| Amount Available**:** | **To be determined** |
| Unit Cost | |
| Budget Requirements or Restrictions **(TRG Only)**: | Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant. |
| DSHS Service Category Definition: | Direct people living with HIV (PLWH) to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services. |
| Local Service Category Definition: | AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential ADAP enrollees to explain ADAP program benefits and requirements and assist PLWHs with the submission of complete and accurate ADAP applications. AEWs will ensure benefits continuation through timely completion of annual re-certifications by the last day of the PLWH's birth month and attestations six months later to ensure there is no lapse in ADAP eligibility and/or loss of benefits. Other responsibilities will include:<br>• Track the ADAP application process to ensure submitted applications are processed as quick as possible, including prompt follow-up on pending applications to gather missing or questioned documentation as needed.<br>• Maintain ongoing communication with designated THMP staff to aid in resolution of PLWH inquires and questioned applications; and to ensure any issues affecting pending applications and/or PLWHs are mediated as quickly as possible.<br><br>AEWs must maintain relationships with the Ryan White ADAP Network (RWAN). |
| Target Population (age, gender, geographic, race, ethnicity, etc.): | People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program. |
| Services to be Provided: | Services include but are not limited to provision of education on available benefits programs applicable to the PLWH; completion of ADAP application including enrollment/recertification/six-month attestation; aid the PLWH in gathering all required supporting documentation to complete benefits application(s) including ADAP; provide a streamlined process for submission of completed ADAP applications and/or other benefits applications; assist in benefits continuation including six-month attestation and necessary follow-up; liaison with THMP and the PLWH throughout the ADAP application process |
| Service Unit Definition(s) **(TRG Only)**: | One unit of service is defined as 15 minutes of direct PLWH services or coordination of application process on behalf of PLWH. |
| Financial Eligibility: | Income at or below 500% of Federal Poverty Guidelines |
| Eligibility for Service: | People living with HIV in the Houston HDSA |
| Agency Requirements **(TRG Only)**: | Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS.<br><br>Agency must obtain and maintain access to TakeChargeTexas, the online system to submit THMP applications. |
| Staff Requirements: | Not Applicable. |
| Special Requirements **(TRG Only)**: | The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services Standards of Care**. The agency must have |

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| | policies and procedures in place that comply with the standards ***prior*** to delivery of the service. |

## *FY 2025 RWPC "How to Best Meet the Need" Decision Process*

| Step in Process: **Council** | | Date: **06/13/2024** |
|---|---|---|
| Recommendations: | Approved: Y:_____ No: _____<br>Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |

| Step in Process: **Steering Committee** | | Date: **06/06/2024** |
|---|---|---|
| Recommendations: | Approved: Y:_____ No: _____<br>Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |

| Step in Process: **Quality Improvement Committee** | | Date: **05/14/2024** |
|---|---|---|
| Recommendations: | Approved: Y:_____ No: _____<br>Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |

| Step in Process: **HTBMTN Workgroup #1** | Date: **04/16/2024** |
|---|---|
| Recommendations: | Financial Eligibility: |
| 1. | |
| 2. | |
| 3. | |

# RYAN WHITE PART B/DSHS STATE SERVICES
# 24-25 HOUSTON HSDA STANDARDS OF CARE
# REFERRAL FOR HEALTH CARE
# ADAP ENROLLMENT WORKERS

Effective Date: April 1, 2024/September 1, 2024

**HRSA Definition:**
Referral for Health Care and Support Services directs a PLWH to needed core medicalor support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist people living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category. Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management servicecategory (i.e., Medical Case Management or Non-Medical Case Management).

**DSHS Definition: (If Applicable)**
Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible PLWH to obtain access to other public and private programs for which they may be eligible.

Benefits counseling: Services should facilitate a PLWH's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting PLWH in identifying all available health and disability benefits supported by funding streams other RWHAP Part B and/or State Services funds. PLWH should be educated about and assisted with accessing and securing all available public and private benefits and entitlement programs.

Health care services: PLWH should be provided assistance in accessing health insurance or Marketplace health insurance plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting PLWH's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

**Local Definition:**
AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential ADAP enrollees to explain ADAP program benefits and requirements and assist PLWHs with the submission of complete and accurate ADAP applications. AEWs will ensure benefits continuation through timely completion of annual re-certifications by the last day of the PLWH's birth month and attestations six months later to ensure there is no lapse in ADAP eligibility and/or loss of benefits. Other responsibilities will include:

- Track the ADAP application process to ensure submitted applications are processed as quick as possible, including prompt follow-up on pending applications to gather missing or questioned documentation as needed.
- Maintain ongoing communication with designated THMP staff to aid in resolution of PLWH inquires and questioned applications; and to ensure any issues affecting pending applications and/or PLWHs are mediated as quickly as possible.

AIDS Drug Assistance Program (ADAP) Enrollment Workers will be co-located at Ryan-White Part A funded primary care providers to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).

**Scope of Services:**
Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible PLWH to obtain access to other public and private programs for which they may be eligible.

AEW Benefits Counseling: Services should facilitate a PLWH's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting PLWH in identifying all available health and disability benefits supported by funding streams other than RWHAP Part B and/or State Services funds. PLWH should be educated about and assisted with accessing and securing all available public and private benefits and entitlement programs.

Health Care Services*:* PLWH should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Services focus on assisting PLWH's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.

| Standard | Evidence |
|---|---|
| **Program** | |
| 1.1 Provision of Service<br>Staff will educate PLWH about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources.<br><br>ADAP Enrollment Workers (AEW) will meet with new potential and established ADAP enrollees to:<br>1. Explain ADAP program benefits and requirements<br>2. Assist PLWH and or staff with the submission of complete, accurate ADAP applications<br>3. Ensure there is no lapse in ADAP eligibility and loss of benefits, and<br>4. AEW will maintain relationships through the Ryan White ADAP Network (RWAN) | • Provision of service per established criteria documented in the primary service record. |
| 1.2 Initial Provision of Education<br>The initial education to PLWH regarding the THMP process should include, but not limited to:<br>• Discussion of confidentiality, specific to the THMP process including that THMP regards all information in the application as confidential and the information cannot be released, except as allowed by law or as specifically designated by the PLWH.<br>• Applicants should realize that their physician and pharmacist would also be aware of their diagnosis.<br>• Discussion outlining that approved medication assistance through THMP may require a $5.00 co-payment fee per prescription to the participating pharmacy for each month's supply at the time the drug is dispensed and the availability of financial assistance for the dispensing fee.<br>• Discussion outlining the recertification process, specific to THMP eligibility, including birth month recertification, half-birth month attestation and consequences of lapse. | • Initial education per established criteria documented in the primary service record.<br>• Exceptions documented in the primary service record. |
| 1.3 Benefits Counseling<br>Activities should be individualized to the PLWH and facilitate access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure PLWH are receiving all needed public | • Benefits counseling documented in the primary service record.<br>• Completed applications as appropriate and per established timeframe documented in the primary service record. |

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| and/or private benefits and/or resources for which they are eligible.<br><br>Staff will explore the following as possible options for PLWH, as appropriate:<br>• AIDS Drug Assistance Program (ADAP)<br>• Health Insurance Plans/Payment Options (CARE/HIPP, COBRA, OBRA, Health Insurance Assistance (HIA), Medicaid, Medicare, Private, ACA/ Marketplace)<br>• SNAP<br>• Pharmaceutical Patient Assistance Programs (PAPS)<br>• Social Security Programs (SSI, SSDI, SDI)<br>• Temporary Aid to Needy Families (TANF)<br>• Veteran's Administration Benefits (VA)<br>• Women, Infants and Children (WIC)<br>• Other public/private benefits programs<br>• Other professional services<br><br>Staff will assist eligible PLWH with completion of benefits application(s) as appropriate within fourteen (14) business days of the eligibility determination date.<br><br>Conduct a follow-up within ninety (90) days of completed application to determine if additional and/or ongoing needs are present. | • Follow-up per established timeframe and result(s) of application documented in the primary service record.<br>• Exceptions documented in the primary service record. |
| <u>1.4 Healthcare Services</u><br>PLWH should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs.<br>• Eligible PLWH will be referred to Health Insurance Premium and Cost-Sharing Assistance (HIA) to assist PLWH in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake.<br><br>Eligible PLWH should be referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the PLWH's needs, with education provided to the PLWH on how to access these services.<br>• Eligible PLWH are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the PLWH's needs, with education provided to the PLWH on how to access these services. | • Assistance accessing healthcare documented in the primary service record.<br>• Referral education on how to access the service documented in the primary service record.<br>• Follow-up for referrals per established timeframe documented in the primary service record.<br>• Exceptions documented in the primary service record. |

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| Staff will follow-up within (10) business days of an applicable referral provided to HIA, any core or support service to ensure the PLWH accessed the service(s). | |
| 1.5 THMP Intake Process<br>Staff are expected to meet with new/potential PLWH to complete a comprehensive THMP intake including explanation of program benefits and requirements. The intake will also include the determination of PLWH eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI).<br><br>Staff should identify and screen PLWH for third party payer and potential abuse<br><br>Staff should obtain, maintain, and submit the required documentation for PLWH application including residency, income, and the THMP Medical Certification Form (MCF). | • THMP education to new/potential PLWH documented in the primary service record.<br>• Completed THMP application and supporting documentation (including proof of residency, income and MCF) documented in the primary service record. |
| 1.6 Benefits Continuation Process (ADAP)<br>ADAP Enrollment Workers are expected to meet with new/potential and established ADAP enrollees; explain ADAP program benefits and requirements; and assist PLWH and or staff with the submission of complete, accurate ADAP applications.<br><br>Birth Month/Recertification<br>• Staff should conduct annual recertifications for enrolled PLWH in accordance with THMP policies. Recertification should include completion of the ADAP application, obtaining and verifying all eligibility documentation and timely submission to THMP for approval.<br>• Recertification process should include screening PLWH for third party payer to avoid potential abuse.<br>• Complete ADAP application includes proof of residency, proof of income, and the THMP Medical Certification Form (MCF).<br>• Staff must ensure Birth Month/Recertifications are submitted by the last day of PLWH's birth month to ensure no lapse in program benefits.<br>• Proactively contact ADAP enrollees 60-90 days prior to the enrollee's recertification deadline to ensure all | • Attempts to contact PLWH for attestations and recertifications per established timeframe documented in the primary service record.<br>• Completed attestations and recertifications documented in the primary service record.<br>• Lapse benefits due to non-completion of timely recertification/attestation documented in the primary service record.<br>• Exceptions documented in the primary service record. |

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| necessary documentation is collected and accurate to complete the recertification process on or before the deadline.<br><br>Half-Birth Month/6-month Self Attestation<br>• Staff should conduct a 6-month half-birth month/self-attestation for all enrolled PLWH in accordance with THMP policies. Staff will obtain and submit the PLWH's self-attestation with any applicable updated eligibility documentation.<br>• Proactively contact ADAP enrollees 60-90 days prior to the enrollee's attestation deadline to ensure all necessary documentation is collected and accurate to complete the attestation on or before the deadline.<br>Half-birth/6-month self-attestations must be submitted by the last day of the PLWH's half-birth month to ensure no lapse in program benefits | |
| <u>1.7 TCT Application Process</u><br>The TakeChargeTexas (TCT) Application Process is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process.<br>• ADAP Applications (with supportive documentation) must be completed through the TCT Application Process for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload.<br>• ADAP applications should be completed according to the THMP established guidelines and applicable guidelines as given by AA.<br>• To ensure timely access to medications, all completed ADAP applications must be completed in TCT within one (1) business day of completion<br>• To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed application in TCT.<br>• Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction. | • Policies are in place at all locations that are funded in the state of Texas with RWHAP Part B and State Services funds that ensure TCT information is protected and maintained to ensure confidentiality.<br>• Local policies and procedures are in place relating to TCT and the data collected through TCT.<br>• Uploaded THMP application per established timeframe documented in TCT.<br>• Notification of THMP upload per established timeframe documented in primary service record. |
| <u>1.8 Tracking of THMP Application</u><br>Track the status of all pending applications and promptly follow-up with applicants regarding missing | • Tracking of application status documented. |

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| documentation or other needed information to ensure completed applications are submitted as quickly as feasible<br><br>Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible | • Follow-up for missing or other information documented in primary service record. |
| 1.9 Case Closure Summary<br>PLWH who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the primary service record.<br><br>The case closure summary must include a brief synapsis of all services provided and the result of those services documented as 'completed' and/or 'not completed.' A supervisor must sign the case closure summary. Electronic signatures are acceptable. | • Case closure summary per established criteria documented in primary service record. |
| **Administrative** | |
| 2.1 Program Policies and/or Procedures<br>Program will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the AEW service. Program will disseminate policies and/or procedures to providers seeking to utilize the service.<br><br>Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards. | • Program's Policies and Procedures document systems to comply with:<br>▪ DSHS Universal Standards<br>▪ TRG Contract and Attachments<br>▪ Standards of Care<br>▪ Collection of Performance Measures |
| 2.2 Staff Education<br>Education can be defined locally, but must at minimum require a high school degree or equivalency | • Staff education documented in the personnel file. |
| 2.3 Staff Qualifications<br>All personnel providing care shall have (or receive training) in the following minimum qualifications:<br>• Ability to work with diverse populations in a non-judgmental way<br>• Working with Persons Living With HIV/AIDS or other chronic health conditions<br>• Ability to (demonstrate) or learn health care insurance literacy, (Third Party Insurance and Affordable Care Act (ACA) Marketplace plans). | • Assessment of staff qualifications documented in personnel file.<br>• Exceptions documented in personnel file.<br>• Training to increase staff qualifications documented in personnel file. |

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| • Ability to perform intake/eligibility, referral/ linkage and/or basic assessments of PLWH needs preferred.<br>  ➢ Data Entry<br>• Quickly establish rapport in respectable manner consistent with the health literacy, preferred language, and culture of prospective PLWH | |
| 2.4 Staff Training<br>AEWS must complete the following:<br>• THMP Training Modules within 30 days of hire<br>• Complete the DSHS ADAP Enrollment Worker (AEW) Regional update at earliest published date after hire<br>• DSHS TCT Document Upload Training (to include TRG upload observation module), completed no later than (45) days after completing TCT certificate process<br>• Data Security and Confidentiality Training<br>• Complete all training required of Agency new hires, including any training required by DSHS HIV Care | • Completion of training requirements documented in personnel file.<br>• Materials for training and continuing education (agendas, handouts, etc.) are on file. |
| 2.6 Language Accessibility<br>Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services.<br><br>Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services.<br><br>Subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations. | • Language accessibility policies and documentation of training on policies are available for on-site review.<br>• Print and multimedia materials meet requirements. |
| 2.7 Trauma-Informed Service Delivery (TISD)<br>Trauma-Informed Approaches (TIA) is a universal framework that any organization can implement to build a culture that acknowledges and anticipates that many of the people being served and those delivering the services have histories of trauma and that the environment and interpersonal interactions within an organization can exacerbate the physical, mental, and behavioral manifestations of trauma.<br><br>Trauma-informed care is a service delivery approach focused on an understanding of and responsiveness to the | • Review of policies and procedures evidence incorporation of TIA.<br>• Staff training is documented.<br>• Systems and workflow revised to promote TISD. |

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| impact of trauma. Trauma-informed care is not a one-size-fits-all approach to service delivery. It's not a program. It's a set of principles and approaches that can shape the ways that people interact within an organization, with clients, patients, customers, and other stakeholders, and with the environment. "A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues."<br><br>Trauma-informed service delivery (TISD) requires that:<br>• Policies are reviewed and revised to ensure that they incorporate trauma-informed approaches and resist retraumatizing the people being served and the staff providing the services.<br>• Staff are trained to be aware of trauma and avoid processes and practices that may retraumatize survivors.<br>• Systems and workflows should be altered to support the environment that promotes trauma-informed care. | |
| 2.8 Service Delivery Back-Up/Redundancy<br>Since the THMP Application Process in electronic in nature, Subrecipients should have a system by which they identify and train employees to serve a back-up for the funded AEW when that employee is unavailable to assist PLWH. | • Access to TCT system<br>• Completed training from TRG |

**References**


- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 43-44. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 42-43. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- DSHS Policy 591.000, Section 5.3 regarding Transitional Social Service linkage.
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Trauma Informed Approaches: https://www.traumapolicy.org/topics/trauma-informed-care

- Trauma Informed Care: https://www.traumapolicy.org/topics/trauma-informed-care and https://www.nih.gov/

# RYAN WHITE PART B/DSHS STATE SERVICES
# 24-25 QUALITY ASSURANCE MEASURES
# REFERRAL FOR HEALTH CARE
# ADAP ENROLLMENT WORKERS

1. Percentage of PLWH with documented evidence of education provided on other public and/or private benefit programs in the primary service record.
2. Percentage of PLWH with documented evidence of other public and/or private benefit applications completed as appropriate within 14 business days of the eligibility determination date in the primary service record.
3. Percentage of eligible PLWH with documented evidence of the follow-up and result(s) to a completed benefit application in the primary service record.
4. Percentage of PLWH with documented evidence of assistance provided to access health insurance or Marketplace plans in the primary service record.
5. Percentage of PLWH who received a referral for other core services who have documented evidence of the education provided to the PLWH on how to access these services in the primary service record.
6. Percentage of PLWH who received a referral for other support services who have documented evidence of the education provided to the PLWH on how to access these services in the primary service record.
7. Percentage of PLWH with documented evidence of referrals provided for HIA assistance that had follow-up documentation within 10 business days of the referral in the primary service record.
8. Percentage of PLWH with documented evidence of referrals provided to any core services that had follow-up documentation within 10 business days of the referral in the primary service record.
9. Percentage of PLWH with documented evidence of referrals provided to any support services that had follow-up documentation within 10 business days of the referral in the primary service record.
10. Percentage of PLWH who are no longer in need of assistance through Referral for Health Care and Support Services that have a documented case closure summary in the primary service record.

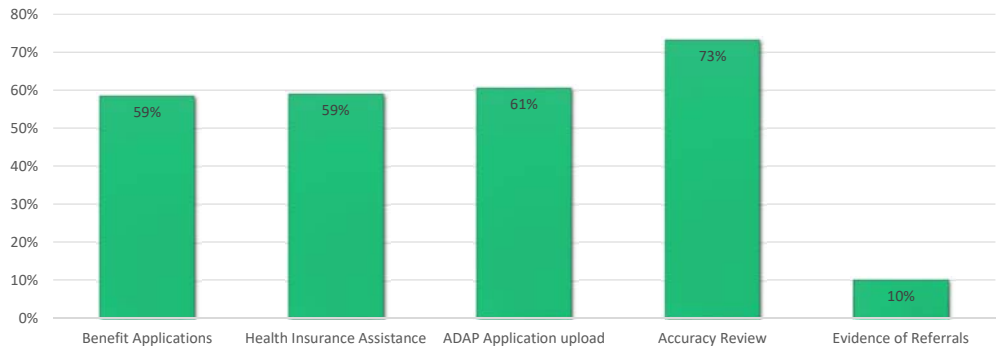
# Referral for Healthcare

ADAP ENROLLMENT WORKER (AEW)

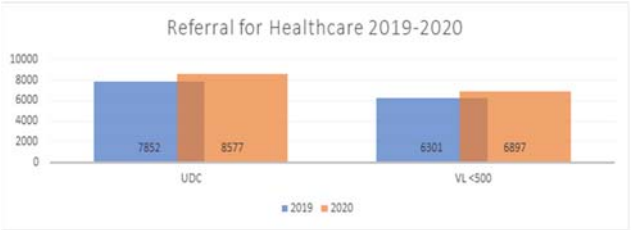
## Description of Service

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

# Chart Review Highlights- 2019



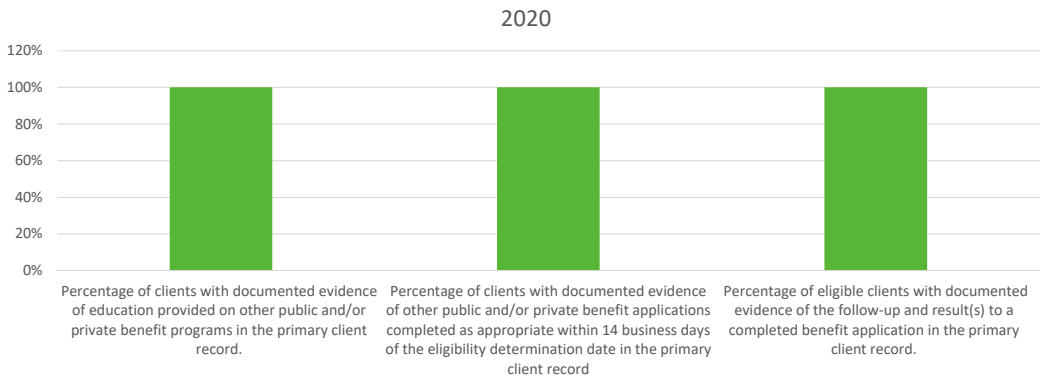

AEW workers provided assistance with 4035 applications, 1797 attestations, and 2446 recertifications during the calendar year. They also entered 18,928 service encounters!




# Referral for Healthcare

Referral for Healthcare- AEW is the most highly utilized service in our HSDA. From calendar year 2019 to 2020 there was an 8.5% increase in utilization for AEW services. The AEW workers completed over thirty-one thousand (31,869 UOS) units of service in 2020. In 2020, a little over 80% of clients accessing this service has a viral load count less than 500 copies/ml.

# AEW Chart Review Highlights- 2020



NASTAD

2023 NATIONAL RWHAP PART B ADAP MONITORING PROJECT ANNUAL REPORT

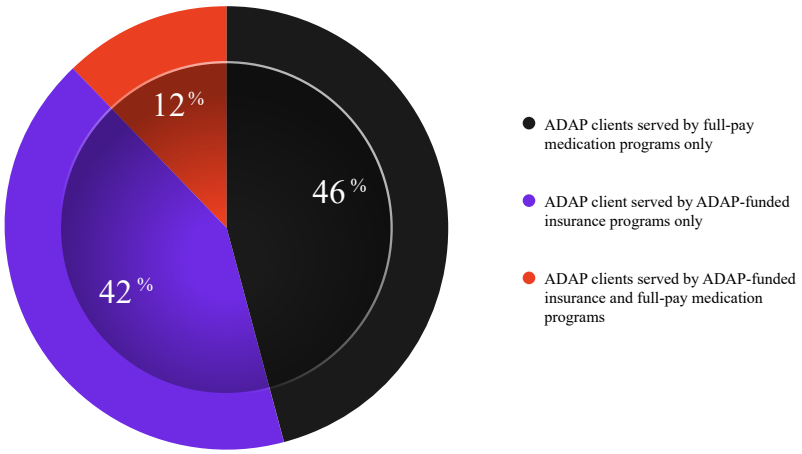
SECTION 3

# Meeting the Need: Ensuring Access to Essential Medicines for People Living with HIV/AIDS

In CY2021, among the 47 jurisdictions responding to the annual RWHAP Part B ADAP Monitoring Project survey, 233,189 clients were served by ADAPs, representing 20% of the nearly 1.2 million people estimated to be living with HIV in the United States at the end of 2019. Approximately 46% were served by ADAPs' full-pay medication programs only[2], 42% were served by the ADAP-funded insurance program only[3], and 12% were served by both the ADAP-funded insurance program and the full-pay medication program.[4]

CHART 3. ↘VIEW LARGER

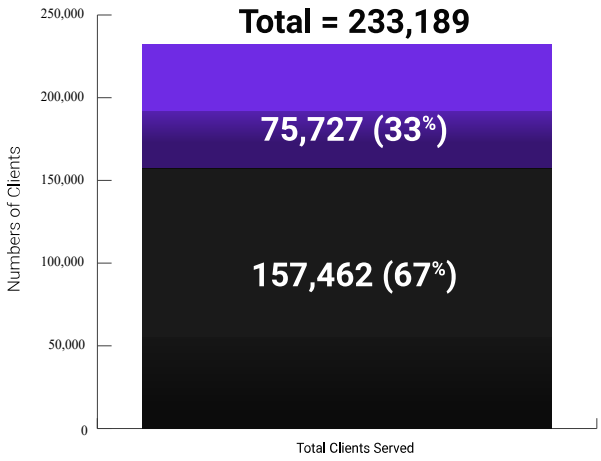
## ADAP Clients Served, by Program Type, CY2021




***Note:*** *47 programs reported CY2021 data. Alabama, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Maryland, Mississippi, Northern Mariana Islands, Republic of Palau, US Virgin Islands, Virginia, and West Virginia did not provide data.*

CHART 4. ⤡VIEW LARGER

## ADAP Clients Served and Top Ten States, CY2021




| State/Territory | Clients Served, CY2021 |
|---|---|
| California | 30,981 |
| Florida | 28,030 |
| Texas | 22,537 |
| New York | 20,731 |
| Georgia | 13,414 |
| North Carolina | 10,393 |
| Illinois | 9,069 |
| Puerto Rico | 8,196 |
| Tennessee | 7,588 |
| Pennsylvania | 6,523 |
| **Total** | **157,462** |

***Note:*** *47 programs reported CY2021 data. Alabama, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Maryland, Mississippi, Northern Mariana Islands, Republic of Palau, US Virgin Islands, Virginia, and West Virginia did not provide data.*

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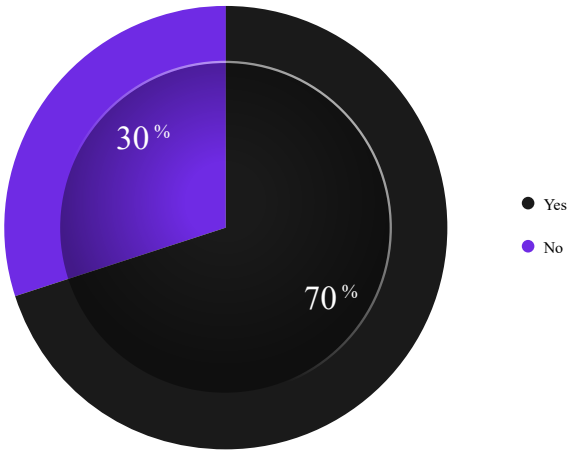
CHART 5. ⤡VIEW LARGER

## ADAP Coordination with Medicaid, CY2021




***Note:*** *33/47 (70%) programs that reported CY2021 data noted that they coordinate with their state Medicaid program to verify client eligibility.*

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To fulfill their mission and purpose in supporting equitable access to treatment and optimal health outcomes, ADAPs must develop and maintain systems that are responsive to the challenges faced by their clients. As stipulated

by the Ryan White CARE Act, individuals served by RWHAP and ADAP are low-income and under/uninsured. Among all ADAP clients served during CY2021 in a responding jurisdiction, 44% had incomes at or below 100% of the federal poverty level (FPL) whereas 11.6% of the general population were living at or below the FPL in 2021. The majority (68%) of ADAP clients served in CY2021 had incomes at or below 200% FPL.

Less than half (43%) of ADAP clients served in CY2021 were Black, brown, indigenous, or other people of color, with the majority of clients of color reported as Black/African American. For a five-year comparison, the proportions of ADAP clients who are Black/African American in CY2021 (37%) has not changed significantly compared with CY2016 (39%). The proportion of ADAP clients who are white has increased, from 48% in CY2016 to 55% in CY2021.

By ethnicity, 31% of ADAP clients served in CY2021 were reported as Hispanic/Latinx, compared with 26% of ADAP clients served in CY 2016.[5]

The majority of ADAP clients served in CY2021 identified as male (79%) whereas 19% identified as female and 1% as transgender. Comparatively, 49% and 51% of the U.S. population in 2021 were reported as male and female, respectively. This difference is reflective of the disproportionate prevalence of HIV among men nationally; 78% of all adult and adolescent PLWHA in 2019 were male.

Effective antiretroviral regimens have enabled many PLWHA, including ADAP clients, to achieve a near-normal life expectancy and experience fewer AIDS-related conditions (e.g., opportunistic infections). As a result, the proportion of ADAP clients who are older – and consequently facing an increased risk of non-AIDS-related health complications (e.g., cardiovascular disease and cancer) and/or potentially requiring wrap-around support for outpatient medications covered under Medicare Part B or D – has and will continue to grow. In CY2021, the majority (57%) of ADAP clients served were 45 years or older; 11% were 65 years or older. Comparatively, in CY2016, while the same percentage of clients were 45 years and older, 8% were 65 years or older.

CHART 6. ↘VIEW LARGER

## ADAP Clients Served, by Demographic, CY2021


***Note:*** *47 programs reported CY2021 data. Alabama, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Maryland, Mississippi, Northern Mariana Islands, Republic of Palau, US Virgin Islands, Virginia, and West Virginia did not provide data. Percentages may not total 100% due to rounding.*

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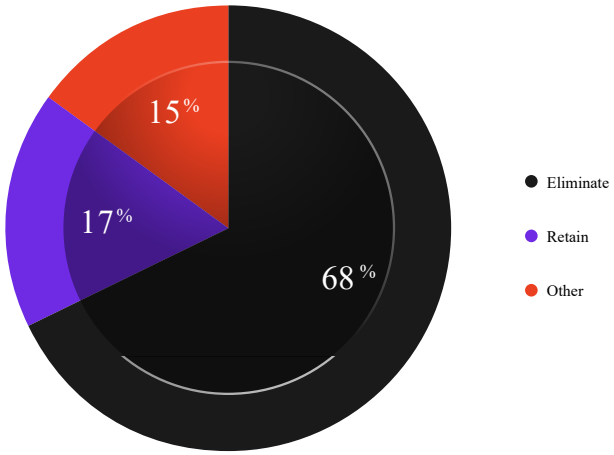
To help ensure that RWHAP maintains access to essential treatment, care, and support services, HRSA HAB released in October 2021 Policy Clarification Notice (PCN) 21-02, *Determining Client Eligibility and Payor of Last Resort in the Ryan White HIV/AIDS Program (RWHAP)*. The updated guidance eliminates the six-month client eligibility recertification requirement for RWHAP programs, including ADAPs, instead allowing recipients and subrecipients to conduct timely eligibility confirmation in accordance with their own policies and procedures. The PCN also states affirmatively that immigration status is irrelevant for the purposes of eligibility for RWHAP services.

As of July 1, 2022, 32 of 47 responding ADAPs have moved to eliminate the six-month recertification requirement. A number of ADAPs are also involved in jurisdiction-wide efforts to adopt unified enrollment policies and procedures across RWHAP parts.

CHART 7. ⤡VIEW LARGER

## Planned Changes to Six-Month Recertification Requirements Following Release of PCN 21-02, as of July 1, 2022




*See Table 13 for "Other" response details.*

***Note:*** *47 programs reported CY2021 data. Alabama, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Maryland, Mississippi, Northern Mariana Islands, Republic of Palau, US Virgin Islands, Virginia, and West Virginia did not provide data.*

# Downloads

Table 5. Total ADAP Clients Enrolled, Served, and Disenrolled, CY2021

Table 6. ADAP Client Eligibility Requirements, as of January 1, 2021

Table 7. ADAP Clients Served by Race, CY2021

Table 8. ADAP Clients Served by Ethnicity, CY2021

Table 9. ADAP Clients Served by Age, CY2021

Table 10. ADAP Clients Served by gender, CY2021

Table 11. ADAP Clients Served by Income Level, CY2021

Table 12. ADAP Clients Served by Other Payers, CY2021

Table 13. Planned ADAP Client Eligibility Policy Changes Following Release of PCN 21-02, as of July 1, 2022

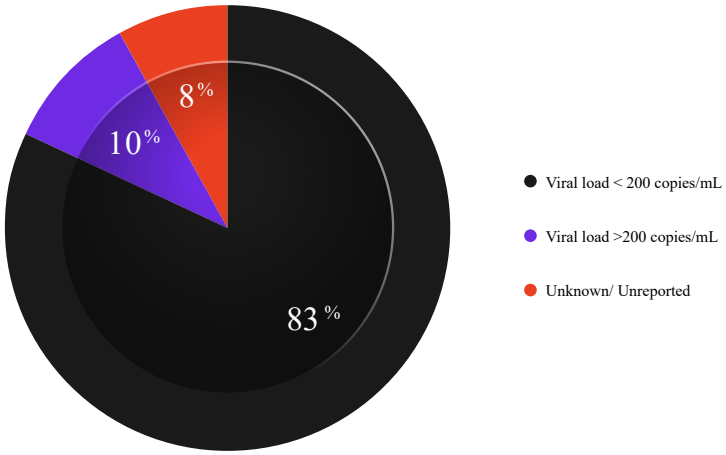
## Virologic Suppression Outcomes

Eighty-three percent of ADAP clients served by the 47 jurisdictions providing data were reported as being virally suppressed based on their most recent viral load recorded as of December 31, 2021. This is significantly more than the estimated 65.5% of all people living with diagnosed HIV infection who were virally suppressed by year-end 2018 and alive by year-end 2019.

For a five-year comparison, 81% of ADAP clients served in CY2016 were reported as virally suppressed (52 programs reporting data). Sixty-three percent of ADAP clients served in 2014 were reported as virally suppressed, the earliest year in which these data were available (47 programs reporting data). This significant change over time is a testament to the increasing effectiveness of ADAPs in ensuring and reporting optimal health outcomes among their clients served.

CHART 8. ↘VIEW LARGER

### ADAP Clients Served, by Viral Load, CY2021




***Note:*** *47 programs reported CY2021 data. Alabama, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Maryland, Mississippi, Northern Mariana Islands, Republic of Palau, US Virgin Islands, Virginia, and West Virginia did not provide data. Data reflect clients enrolled in Part B programs over the past 12 months or the most recent 12 months for which data are available.*

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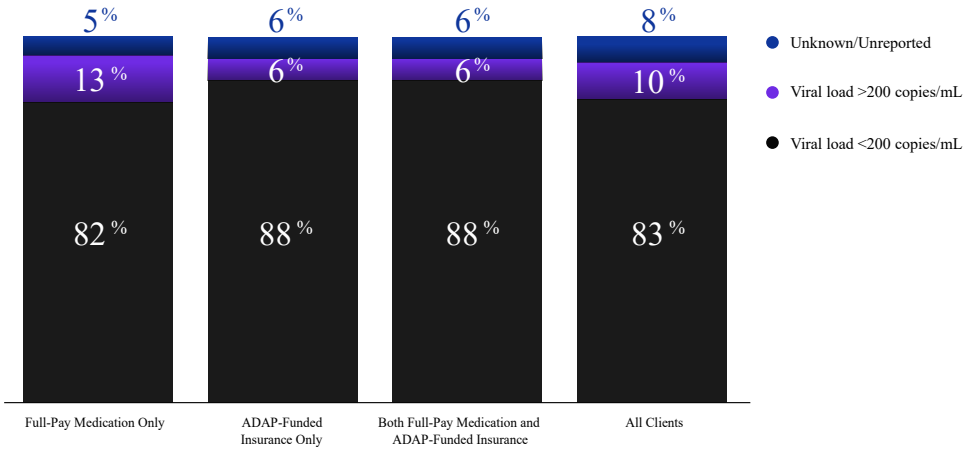
The ADAPs with viral load suppression rates in excess of 90% in CY2021 include Arizona (95%), Florida (91%), Illinois (94%), Iowa (90%), Michigan (91%), Montana (92%), New Mexico (95%), Ohio (94%), Vermont (96%), and Washington State (91%).

These data illustrate that ADAPs EHE, can make meaningful contributions toward widespread viral suppression and, by extension, the EHE initiative.

CHART 9. ⤡VIEW LARGER

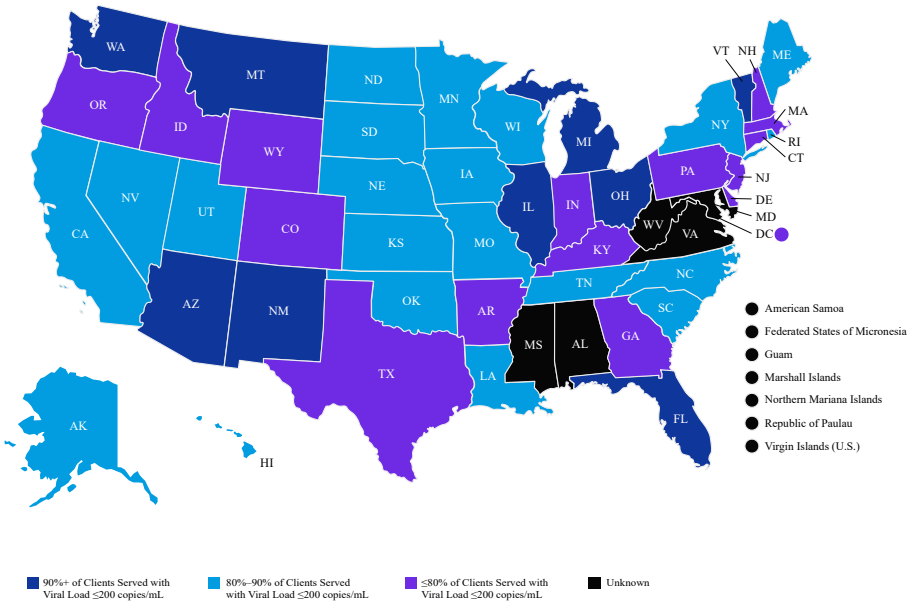
## ADAP Clients Served by Program, by Viral Load, CY2021




***Note:*** *47 programs reported CY2021 data. Alabama, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Maryland, Mississippi, Northern Mariana Islands, Republic of Palau, US Virgin Islands, Virginia, and West Virginia did not provide data. Data reflect clients enrolled in Part B programs over the past 12 months or the most recent 12 months for which data are available.*

CHART 10. ⤡VIEW LARGER

## ADAP Viral load Suppression Rate, by Clients Served, CY2021




***Note:*** *47 programs reported CY2021 data. Alabama, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Maryland, Mississippi, Northern Mariana Islands, Republic of Palau, US Virgin Islands, Virginia, and West Virginia did not provide data*

# Downloads

Table 14. ADAP Clients by Viral Load, CY2021

Table 15. ADAP Sources of Viral Load Data, as of July 1, 2022

## Dynamic Program Expenditures in a Dynamic HIV Care Environment

One of the more notable findings reported in the 2021–2022 *National RWHAP Part B and ADAP Monitoring Project Report* involved a significant increase in ADAP program expenditures from CY2019 to CY2020, totaling $2.22 and $2.43 billion across 47 and 45 jurisdictions providing expenditure data, respectively. Limiting the comparison to jurisdictions providing expenditure data for both years, CY2020 ADAP program expenditures were approximately 10% higher than those reported in CY2019.

A significant increase in prescription drug expenditures, potentially owing to an increased number of prescription drug fills (including 60- and 90-day fills in support of COVID-19 precautions), was identified as a contributor to the significant increase in overall ADAP program expenditures between the two years.

ADAP program expenditure data for CY2021 totaled $2.12 billion. Limiting the comparisons to 43 jurisdictions providing expenditure data in CY2020 and CY2021, expenditures totaled 2.31 billion and $2.09 billion respectively, indicating a 11% decrease in program expenditures between the two years. A corresponding 18% decrease in prescription drug expenditures was also observed.

For CY2019, five ADAP programs reported implementing cost-containment measures. Five jurisdictions either continued cost-containment measures implemented in CY2019 or implemented new cost-containment measures in CY2020. In CY2021, eight jurisdictions, including four jurisdictions that hadn't implemented cost-containment measures in the two years prior, either continued or implemented cost-containment measures. Most programs reported limiting the number of Marketplace or off-Marketplace plans available for premium payment support under their ADAP-funded insurance programs. Two programs reported restricting their formularies, including one ADAP's decision not to add a new ARV product to its formulary. One reported reassigning or reducing staff who were previously funded with ADAP rebate dollars.

Whether overall or program-level expenditure changes, or the implementation of cost-containment measures, are associated with EHE activities or the impact of COVID-19 on program utilization cannot be determined from the data provided.

# Downloads

Table 16. Total ADAP Program Expenditures, CY2021

Table 17. ADAP Formulary Management Practices, CY2021

## Footnotes

[2]Clients "served with full-pay medications" include clients served by the full-pay prescription program for the entire year (or the entirety of a partial year enrolled in the program), with no ADAP coordination with insurance.

[3]Clients "served through an ADAP funded insurance program" includes clients who were enrolled in insurance (i.e., Medicare, Medicaid, private insurance) at any point during the year and for whom payment for premiums and/or cost-sharing was made on their behalf using ADAP funds. Cost-sharing includes any copayments, coinsurance, and/or deductible payments required under the client's insurance plan or program.

[4]Clients "served through full-pay medications and an ADAP funded insurance program" includes clients who either spent part of the year in one program and part of the year in the other or they were primarily served by the ADAP-funded insurance program but required full-pay medication program coverage of medications not covered by their insurance.

[5]Survey respondents provide aggregate race and ethnicity data. Without client-level data, the *National RWHAP Part B ADAP Monitoring Project Annual Report* is unable to provide breakdowns of intersecting race and ethnicity categories (e.g., number of non-Hispanic Black ADAP clients served).

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