NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

2024 COMMON GUIDANCE

NEVADA RYAN WHITE PROGRAM B AND AIDS DRUG ASSISTANCE PROGRAM

Schedule

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SECTION I: UNIVERSAL GUIDANCE

Payer of Last Resort Policy

Once a client is eligible to receive RWPB services, RWPB is considered the payer of last resort, and as such, 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 under:

- Any State compensation program
- An insurance policy, or under any Federal or State health benefits program
- An entity that provides health services on a pre-paid basis

Each agency providing services will have a case closure protocol. The reason for case closure must be properly documented in each client's chart.

By Federal statute, RWPB funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source (Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i) of the Public Health Service (PHS) Act, and Section 300ff-27(b)(7(F) of Title 42 under the US Code). Additionally, DD300ff-15(a)(1)(A) states that all funds received under the grant are added to "to supplement not supplant State funds" to provide HIV related services.

Sub-recipients are expected to make reasonable efforts to identify, secure and exhaust non-RWHAP funds whenever possible before utilizing RWPB Funds for core medical and supportive services. Sub-recipients must ensure that eligible individuals are encouraged, referred to, and assisted in enrolling in other private and public service programs and that such eligibility is consistently assessed, and enrollment pursued. Examples of such programs include, but are not limited to:

Private Health Insurance Waiver	Aging & Disability Housing
Supplemental Nutrition Assistance Program (SNAP)	Medicaid
Temporary Assistance for Needy Families (TANF)	Medicare
Housing Opportunities for Persons with AIDS(HOPWA)	Section 8 Housing
Employer Sponsored Health Insurance Coverage Programs	Other Non-Profit Service

For allowable services, RW funding is the payer of last resort. All sub-recipients shall have a written policy and procedures in-place addressing requirements that reflect the conditions that Ryan White funding will be the last resource used to pay for allowable core medical and supportive services. At a minimum such policy will reflect the following:
Sub-recipients must coordinate with all Ryan White Program Parts (Parts A, B, C and D) when similar service is provided to avoid duplication of services or payments.

All services an eligible Ryan White client receives that are covered by their existing insurance coverage/benefits and/or assistance program must first be billed to that other payer source prior to utilizing Ryan White resources. (Sub-recipients will enter this information into CAREWare Notes within three (3) days of completion.)

- Sub-recipients will retroactively bill other payer sources for covered services.
- Sub-recipients must screen each client to determine if they are eligible to receive

services through other programs at time of eligibility or reassessment, and prior to any referrals made to other Ryan White core medical and/or support services.

Payer of Last Resort Exemptions

Payer of Last Resort Exemptions are directly applicable to Ryan White Part B (RWPB) Core Medical & Support Service providers funded through the Nevada Office of HIV to help improve access to care and ensure continuity of care is provided to both veterans and Native Americans/Alaska Natives, both groups are exempt from the payer of last resort restriction under RWPB requirements.

The purpose of RWPB is to ensure persons living with HIV/AIDS (PLWH) receive HIV/AIDS related medical and support services in alignment with continuity of care standards. RWPB is responsible for providing HIV/AIDS related medical and support services to eligible clients in the most cost-effective delivery system. While Ryan White (RW) funding is the payer of last resort for HIV/AIDS medical and support services, including medications, this policy stands to clarify that two distinct groups are exempt from the payer of last resort requirement.

RWPB recipients and sub recipients may not cite the payer of last resort language to refuse to provide services or to encourage an HIV/AIDS veteran to obtain services from the Veteran's Administration (VA) health care system nor encourage a Native American/Alaska Native to obtain services from the Indian Health Services (IHS) system.

As clarified in Health Resources and Services Administration Policy Notice (PCN) 07-01, Native Americans/Alaska Natives can access RWPB program services for which they are eligible where they choose, regardless of the availability of services that may also be available to them (e.g., through IHS, tribal, or urban Indian health programs and services). Native Americans/Alaska Natives who are eligible for Ryan White services may also utilize Nevada Medication Assistance Program (NMAP) medications and services.

As clarified in PCN 16-01, RW providers should not require eligible RW veterans to access medical or supportive services in the VA system nor deny them access to care and support services, including prescription drugs, that are funded by RWPB. However, RW recipients and sub recipients may refer eligible veterans to the VA for services, when appropriate and available. Should a RW veteran client need to transition care from a RW provider to a VA provider, RW providers will need to work with the VA to ensure coordination of care. This may include continuing to provide RW funded services during any such transition to VA care.

However, RWPB funds cannot be used to duplicate payment for an item or service in which the VA or the IHS has already rendered payment. Payer coordination on behalf of clients must respect client choice of payer in cases where VA, IHS and RW are the available payers.

Marketplace/ Insurance Exchange Exemptions
American Indians and Alaska Natives (AI/ANs) and other people eligible for services through the IHS, tribal programs, or urban Indian programs (like the spouse or child of an eligible Indian) do not have to pay the fee for not having health coverage. This is called having an IHS coverage exemption.

Veterans enrolled in the Veterans health care program (or their eligible beneficiaries) are considered covered under the health care law and do not need to have additional health insurance through the Marketplace/Exchange. Four (4) Additional types of veterans' programs that are considered covered under the health care law include:

- Veterans' health care program
- VA Civilian Health and Medical Program (CHAMPVA)
- Spina bifida health care benefits program
- TRICARE

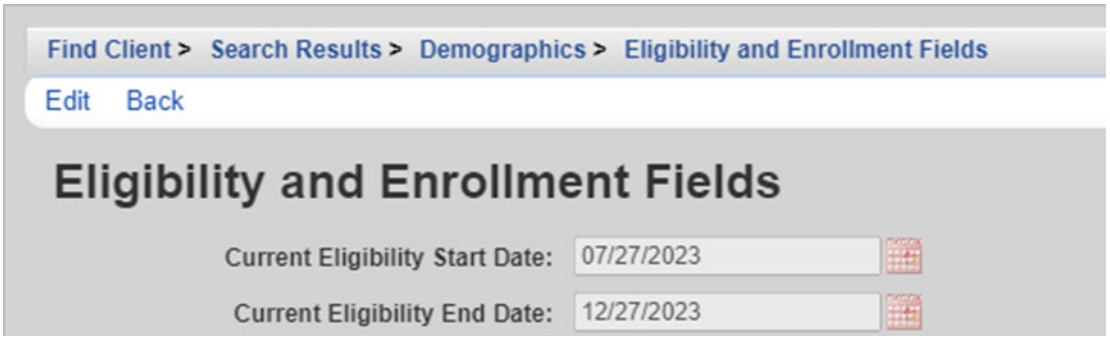
References
HRSA HAB Policy Notice 07-01 Use of Funds for American Indians and Alaska Natives and Indian Health Service Programs
HRSA HAB Policy Notice 16-01 Clarification of the Ryan White HIV/AIDS Program (RWHAP) Policy on Services Provided to Veterans
https://www.healthcare.gov/american-indians-alaska-natives/coverage/
https://www.healthcare.gov/veterans/

Referrals

Instructions
Referrals are an important tool for agencies to ensure clients get the best possible services. They are used to send a client to another agency that provides a service that the referring agency does not provide. For Ryan White Part B there are currently three (3) services that are specific to certain agencies: Nevada Medication Assistance Program (NMAP), Legal Services, and the Administration of Cabenuva.

- Access to Healthcare Network (AHN) handles the NMAP program
- Nevada Legal Services (NLS) providers Other Services: Legal
- Community Outreach Medical Center (COMC) administers the Cabenuva Program

Referral Process for Initiating Agency
When you are sending a referral for services to another agency ensure that the client is currently enrolled in the RWPB Program by looking at the Eligibility and Enrollment Fields tab.



The next set of instructions are shown in images on the following pages.

- Then navigate to the Referrals tab and click Add Referral,

- Select that Date that you are making the referral,
    - Referrals should never be backdated. The date of the referral should reflect the date that the referral is sent
- Always select Internal in the Type section,
- Select *the agency needed* in the Refer-To Provider section,
- Select the Requested Service Category Type appropriate for the client
- Select the appropriate Referral Class based on the client's needs.

Referral Process for Referral Receiving Agency
When a referral for NMAP services is received by the receiving agency, the agency staff will review the requested service, referral notes, and client eligibility information. If the necessary NMAP documents are provided with the initial referral, then the client may be enrolled directly into the requested NMAP medication or health insurance program. If the client is ineligible or refuses to enroll into health insurance coverage, the client will be reassessed for NMAP uninsured medication assistance; up to and including disenrollment from NMAP services. If the client enrolls into insurance coverage, the client will be reassessed for NMAP insured medication assistance and/or health insurance premium assistance.

When receiving a referral for services from another agency ensure that the client is currently enrolled in the RWPB Program by looking at the Eligibility and Enrollment Fields tab.

For specific instructions regarding NMAP referrals, please see the section below.

Nevada Ryan White Part B and Ryan White Part A Mirroring Processes

To provide guidance to Ryan White HIV/AIDS Program A (Part A) and B (Part B) subrecipients on mirroring clients between both parts in their own CAREWare systems, for clients to be able to access services more easily and reduction of system-level administrative burdens.

Part A to a Part B subrecipient for Part B Service:
There are five (5) service categories Part B provides that Part A does not. Those services, along with whom provides those services, are as follows:

Service Category	Subrecipient
Health Insurance Premium & Cost Sharing Assistance or HIP-CS	Access to Healthcare Network (AHN)
Health Insurance to Provide Medication or HIP-Rx	AHN
Other Professional Services: Tax Preparation	AHN
Outpatient/Ambulatory Health Services: Cabenuva Only	Community Outreach Medical Center (COMC)
Other Professional Services: Legal	Nevada Legal Services (NLS)

For subrecipient that have access to Part A and Part B CAREWare for any Part B Service:

- Subrecipient will transfer client's eligibility information and documentation into Part B CAREWare.
- Subrecipient uses Part B CAREWare referral system to send a referral, please follow steps outlined in the Part B Referral Service Standard for completing the process.
- Referred to subrecipient will then provide the service requested.

For Part A subrecipient referring clients to AHN or COMC for their respective services they will complete the following steps:

- Subrecipient uses Part A CAREWare referral system to send a referral, following steps outlined in Part A Referral Service Standard for completing the process.
- After being received, the referred to subrecipient will then enter the client's eligibility information and documentation into Part B CAREWare.
- Referred to subrecipient will then provide the service requested.

NLS can only perform services for those they are able to confirm are Ryan White eligible. Part A subrecipient referring clients to NLS must do one of the following:

- Send an email to NLS with client's name, URN, and eligibility start and end dates;
- Client brings statement from case manager on their subrecipient's letterhead that has confirmation of client's URN and eligibility start and end date; or
- Client provides phone number for case manager and case manager can confirm client's eligibility start and end date for NLS.

Part B to a Part A subrecipient for Part A service:
Five (5) of the six (6) subrecipient funded by Part B in Clark County have access to both Part A and Part B CAREWare. Those five (5) subrecipient are:

- AHN
- Aid for AIDS of Nevada
- Southern Nevada Health District
- AIDS Healthcare Foundation
- COMC

For these subrecipient this is how to refer clients from Part B into Part A if client is already in Part B CAREWare:

- Subrecipient will transfer client's eligibility information and documentation into Part A CAREWare/RWise;
- Referring subrecipient will then contact Tri Young to ensure the eligibility dates match what is listed in Part B CAREWare;
- Subrecipient uses Part A CAREWare referral system to send a referral, following steps outlined in Part A Referral Service Standard for completing the process; or
- Referring subrecipient will then provide service requested.

SECTION II: RYAN WHITE PART B

Profit and Loss Statement Proof of Income

A Profit-Los statement can be used for those who earn money doing odd jobs, day labor, or anything that pays them in cash. Profit and loss statement, as provided by Ryan White, is required for people who are self-employed and/or own a small business. The form can be found in Supplement Forms. This form should be filled out as accurately as possible.

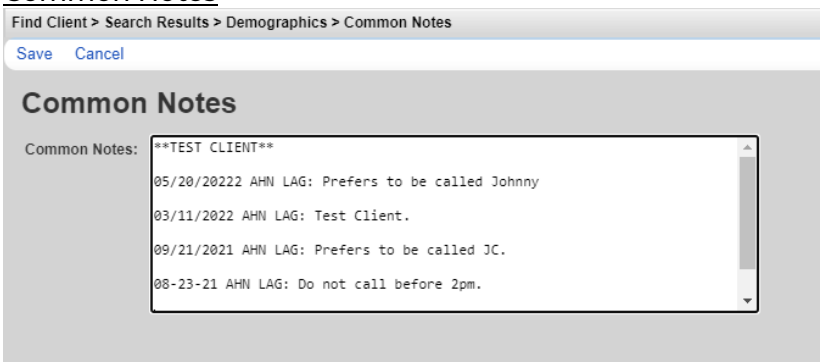
Clients must fill out this documentation at the annual certification. If at the 6-month review there are no changes to self-employment income then the client follows 6-month self-attestation guidelines and indicate there is no change on the Self Attestation Form.

Primer on CAREWare Notes

Types of Notes Sections & Location

Field Name	Location in CAREWare	Requirement
Common Notes	Demographics Tab	Yes
Provider Notes	Demographics Tab	No
User Messages	Client-Side Bar	No
Case Notes	Client-Side Bar	No
Service Notes	Services tab	Yes
Comments from Initiating Agency	Referrals tab	Yes
Comments from Completing Agency	Referrals tab	Yes
Referral Comments	Referrals tab	No
Attachment Properties Comments	Attachment window	Yes

Common Notes



Common Notes are for general comments for all system users, usually as flags for client interactions. Only include information that all providers need to know. When entering a new common note, begin the note with the date, the name of your agency, and your name

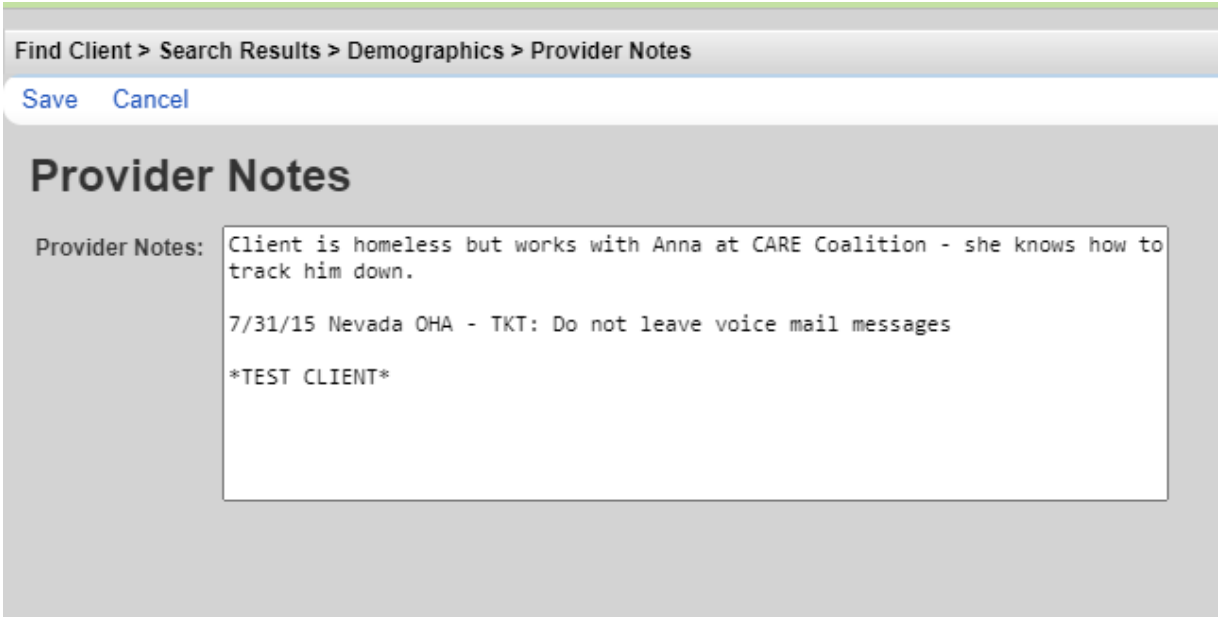
Example: 5/21/2023 Nevada Office of HIV/AIDS – John: Do not leave voicemail messages, do not call before 1:00 pm, works night shift

If a client has a different physical home address that is not their mailing address, please put that information in the first lines and keep that information in the first lines of the Common Notes.

Do not include the client's eligibility dates in the Common Notes Section.

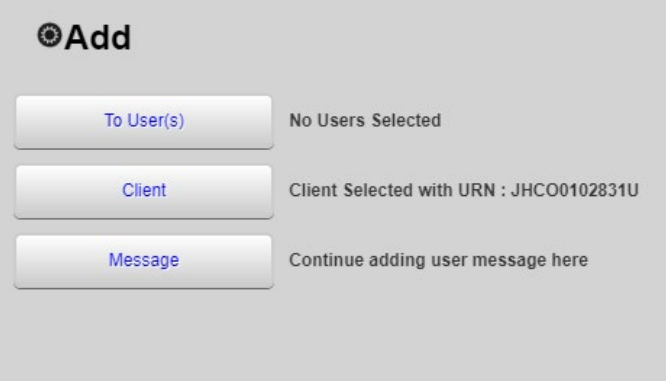
Provider Notes

Provider Notes function similarly but are specific to the provider, so they might include "Client does not want a referral to XYZ Agency" or other information a medical provider would not share with a social services provider, "Client is in treatment with Dr. Suarez for bipolar disorder." These notes can only be viewed and entered by CAREWare users within your provider domain. Each agency can establish its own protocol for the formatting and use of Provider Notes.

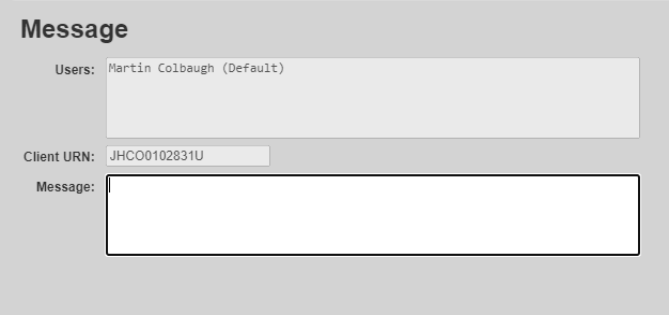


User Messages

User Messages allow users to send each other messages about this client, including messages from the Central Admin user to all users. These messages are flagged on the CAREWare "home page." These messages are directly tied to the client, so general messages cannot be sent and messages to a group cannot be sent.



Click on New Message to create a new message and then click on To User(s) to find the specific user at a specific agency that you would like to communicate with. Remember that if you are communicating pertaining to a referral – that must only be done in the Referrals tab. Communications through here are to be information that you want a specific person to know about this client.



- Do not send any state OoH staff user messages through CAREWare. Use the CAREWareHelp@health.nv.gov email address to ask that state staff call and troubleshoot any client specific question. DO NOT email any personally identifiable information (PII) or protected health information (PHI) in the email body; but please be sure to include client's URN in the subject line.

  Tip: copy and paste the client URN into the message body; we have noticed that there is a glitch within CAREWare that sometimes causes the Client URN field to be deleted upon sending a message.

Case Notes

Case notes can only be seen by each user within your domain but can be shared with another provider on a case-by-case basis. To enter a case note from the Demographics page, click Case Notes

Within the Case Notes window, there is now the benefit of having a larger area to type in, a Spell Check option, a Thesaurus option, and the ability to go back and Append previously entered notes. The administrative officer of CAREWare at your agency is the only staff member with the ability to delete a Case Note.

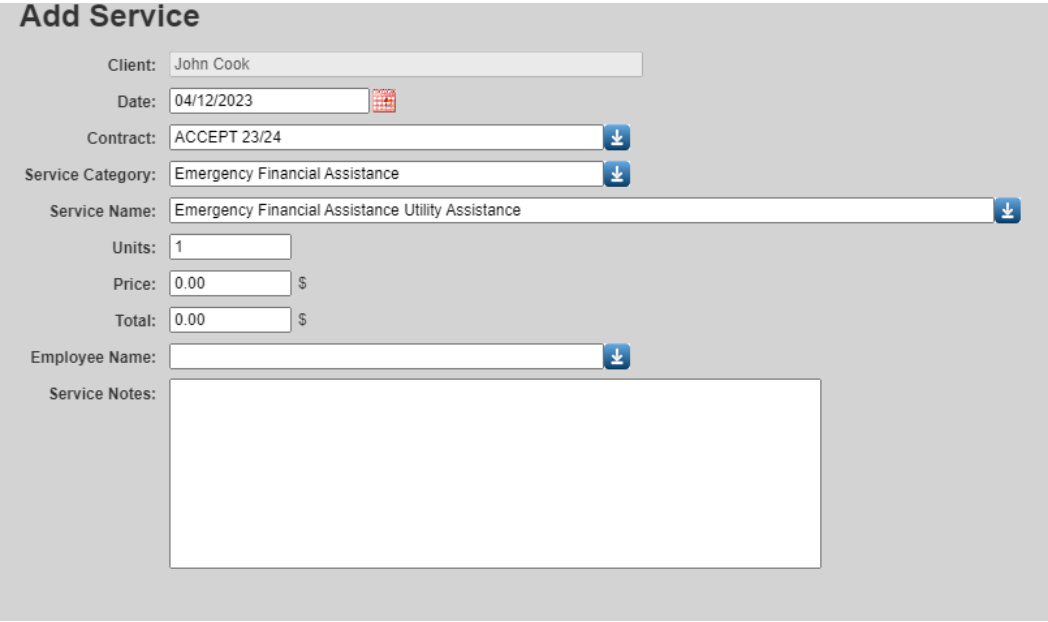
If any provider has a standard template/wording that is used as the baseline for a more individualized case note – please email that wording to CAREWareHelp@health.nv.gov stating that you would like to add a Case Note Template.

Click Add, Enter the Date, select a Case Note Author, and then enter the text of the Case Note.

Click Spell Check and use the Thesaurus, if necessary, then click Save.

Service Notes

Service Notes are a brief yet explanatory way to document the substance of the activity that the provider delivered to the client. Service notes are seen by all providers – so be sure to only include information relevant to other providers and include notes only relevant to the service delivered. More detailed notes related to the service can be entered in Case Notes.



Referral Section

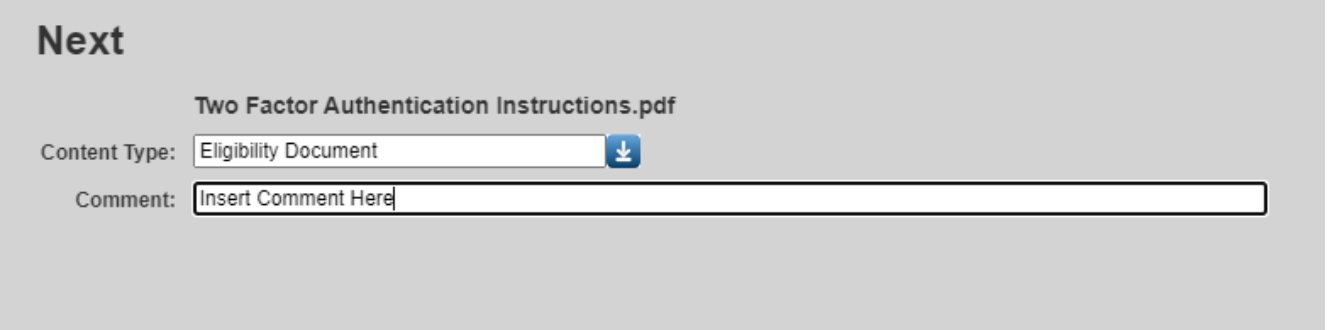
Comments from Initiating Agency

Comments from Initiating Agency are in the Add Referral section in CAREWare and are notes directed to the agency that is going to receive the referral. These referral notes should have a request associated with it. The notes should be clear and concise on what the client needs so the referred to agency can best assist the client.

Comments from Completing Agency

Comments from Completing Agency are in the Referrals tab in CAREWare and are notes indicating the current status and completion of the referral. The notes should be clear and concise enough for whomever initiated the referral to know that the client was assisted.

Attachment Properties Comments
When attaching documents into CAREWare, whether it be referral documents or an Eligibility & Enrollment packet, the Attachment Properties Comments must describe the contents of the attached file.



General Contact Service Notes

When adding Service Notes for a client it is important to enter the correct service category and service name based on the Service Taxonomy. Each service category encompasses a specific set of service names that the subrecipient provides. Sometimes, the subrecipient contacts a client or potential client that does not fit into the specific service categories.

General Contact is a contract set up for all providers to account for client contact situations not covered by specific service names. General Contact is designed for cases where a client is not actively eligible for Ryan White services and needs to be talked to about services or eligibility. It should not be used as a catch-all for contacting clients, as there are services that cover active client contact. General Monitoring, for instance, is there for day-to-day work with active clients to ensure they are getting the care and services they need. Scheduling is a service option under some service categories for when you reach out to an active client to establish a service appointment.

General Contact should only be used when dealing with an inactive client, or when no other service name fits the reason for contacting the client. Please verify using the Service Taxonomy listed above.

Uploading Eligibility Documentation into CAREWare:

When uploading eligibility documentation to a client's CAREWare profile, Referral for Health Care and Support Services (Eligibility) funded subrecipients should make sure all documents in the application packet are submitted as a single document. The consolidated documents may consist of the following: Ryan White Universal Eligibility form 18-04A, proof of income, proof of residency, ID (if provided), proof of insurance (if client has insurance,) and proof of diagnosis (if part of the initial assessment).

Note: Please wait until all eligibility documents, such as 18-04A Universal Eligibility Form and necessary verifications, are collected and client is ready to be made eligible before uploading to CAREWare.

- Employee Insurance Verification Form can be added afterwards if not initially provided.
- 6-Month self-attestation 18-06A, should include any documents showing a change of circumstances such as income, residency, or household size.

If when submitting the 18-06A self-attestation the client states there are no changes, then the form can be uploaded on its own as there is no additional documentation.

- 19-08A Dental Eligibility documentation should be uploaded as its own file, separate from primary eligibility documentation.

If a client brings in proof of a change, such as new proof of income or household size change, subrecipients should make sure any statements or proof of change provided by the client are uploaded as a single file.

File naming convention:

- LastNameFirstName_Annual_Date
- LastNameFirstName_Recertification_Date
- LastNameFirstName_Dental_Date
- LastNameFirstName_Document_Date

Primer on Labs

Background

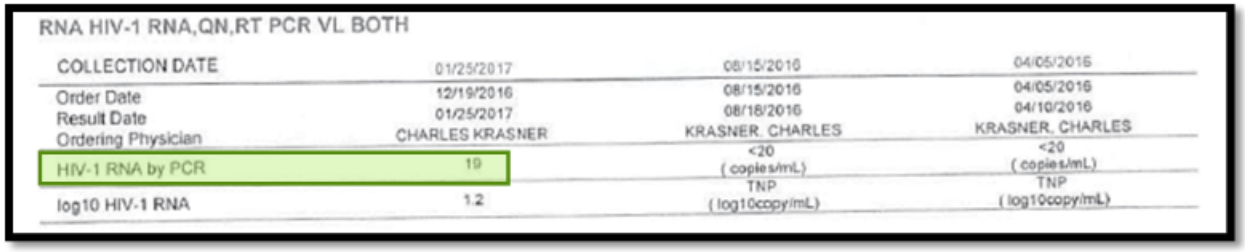
Lab results are a required document for consumers who apply for benefits for RWPB in Nevada. HIV Viral Load and CD4 T-Cell lab results are required for initial and annual enrollment for all consumers. All lab results are required to be entered into the Encounters tab and Lab Results subtab within CAREWare.

Reading Lab Results

Component	Latest Ref Rng	3/13/2017 10:24 AM	3/13/2017 10:24 AM	3/13/2017 10:24 AM	3/13/2017 10:24 AM	3/13/2017 10:24 AM
Sodium	135 - 145 mmol/L			138		
Potassium	3.6 - 5.5 mmol/L			4.0		
Chloride	96 - 112 mmol/L			104		
Co2	20 - 33 mmol/L			30		
Anion Gap	0.0 - 11.9			4.0		
Glucose	65 - 99 mg/dL			84		
Bun	8 - 22 mg/dL			9		
Creatinine	0.50 - 1.40 mg/dL			0.75		
Calcium	8.5 - 10.5 mg/dL			9.4		
AST(SGOT)	12 - 45 U/L			23		
ALT(SGPT)	2 - 50 U/L			16		
Alkaline Phosphatase	30 - 99 U/L			77		
Total Bilirubin	0.1 - 1.5 mg/dL			0.7		
Albumin	3.2 - 4.9 g/dL			4.1		
Total Protein	6.0 - 8.2 g/dL			6.7		
Globulin	1.9 - 3.5 g/dL			2.6		
A-G Ratio				1.6		
Cd4 -T4 Helper Cells	490 - 1600 cells/uL				439 (L)	
Cd8 -T8 Suppressor Cells	150 - 1050 cells/uL				267	
Cd3 Ct	660 - 2200 cells/uL				649 (L)	
Cd4-Cd8 Ratio	0.80 - 6.17 ratio				1.64	
Interpretation					See Note	
Cholesterol,Tot	100 - 199 mg/dL		196			
Triglycerides	0 - 149 mg/dL		144			
HDL	>=40 mg/dL		30 (A)			
LDL	<100 mg/dL		137 (H)			
HIV-1 RNA PCR log						<1.3
HIV PRNA PCR Copy/Ml						<20
HIV RNA PRC Interp	Not Detected					Not Detected
GFR If African American	>60 mL/min/1.73 m 2	>60				
GFR If Non African American	>60 mL/min/1.73 m 2	>60				

In CAREWare for this individual – the HIV Viral Load number was put in as <1.3 which is connected to the HIV logarithmic scale number. Using the logarithmic scale number is incorrect. The purpose of the logarithmic scale is to turn large numbers into more manageable numbers for data presentation. For example, 10,000,000 (ten million) can also be written as 7.0 $\log_{10}$.

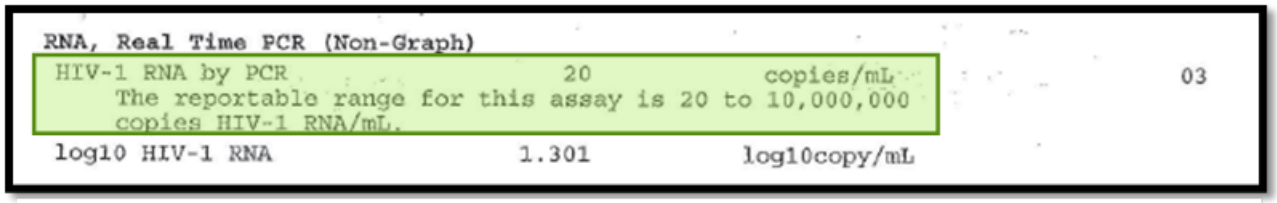
Remember to use the actual Copy number, the assay will be listed as PCR.



RNA HIV-1 RNA,QN,RT PCR VL BOTH

COLLECTION DATE	01/25/2017	08/15/2016	04/05/2016
Order Date	12/19/2016	08/15/2016	04/05/2016
Result Date	01/25/2017	08/18/2016	04/10/2016
Ordering Physician	CHARLES KRASNER	KRASNER, CHARLES	KRASNER, CHARLES
HIV-1 RNA by PCR	19	<20 (copies/mL)	<20 (copies/mL)
log10 HIV-1 RNA	1.2	TNP (log10copy/mL)	TNP (log10copy/mL)

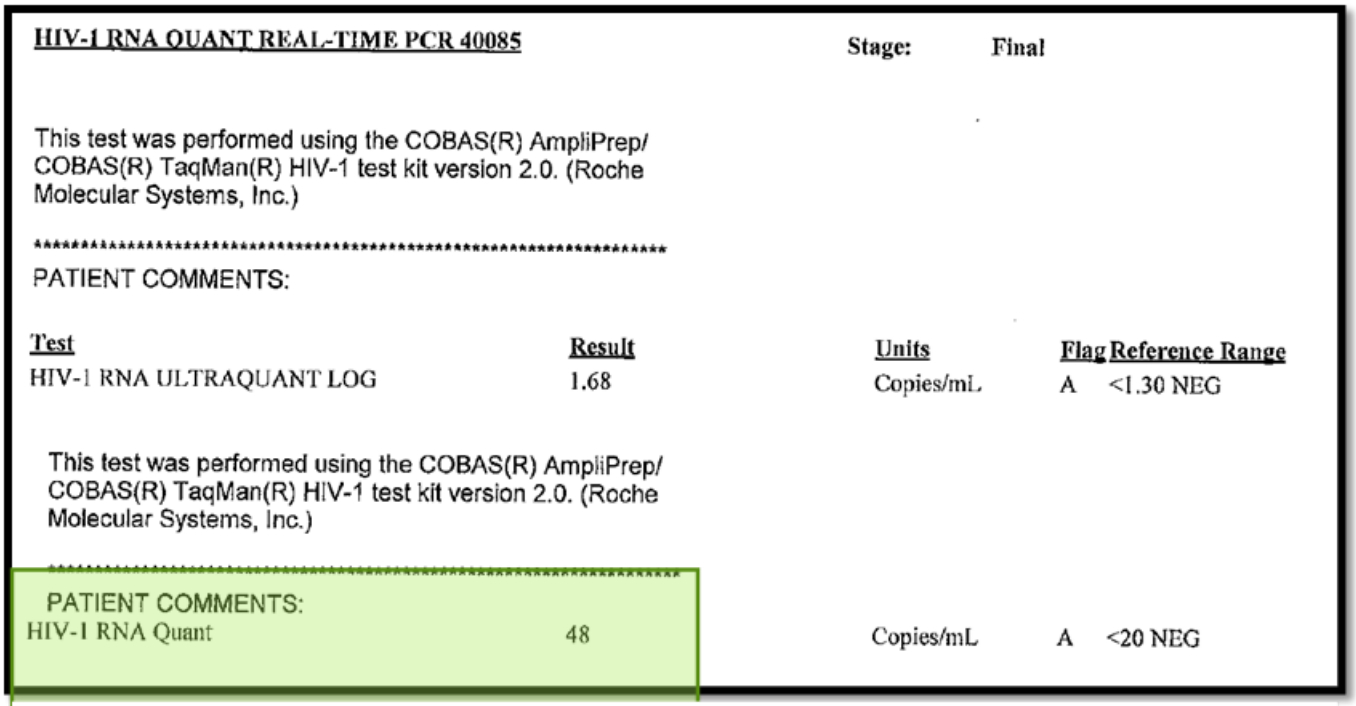
This lab result is more unusual because the sensitivity of the test was able to capture 19 viral load copies. CAREWare had the correct entry at =19. The client's medical provider might explain that the individual can consider themselves virally suppressed.



RNA, Real Time PCR (Non-Graph)

HIV-1 RNA by PCR 20 copies/mL 03
The reportable range for this assay is 20 to 10,000,000 copies HIV-1 RNA/mL.
log10 HIV-1 RNA 1.301 log10copy/mL

The reportable viral load for this individual would be =20 with PCR listed as the assay.



HIV-1 RNA QUANT REAL-TIME PCR 40085 **Stage: Final**

This test was performed using the COBAS(R) AmpliPrep/ COBAS(R) TaqMan(R) HIV-1 test kit version 2.0. (Roche Molecular Systems, Inc.)

****

PATIENT COMMENTS:

Test	Result	Units	Flag	Reference Range
HIV-1 RNA ULTRAQUANT LOG	1.68	Copies/mL	A	<1.30 NEG

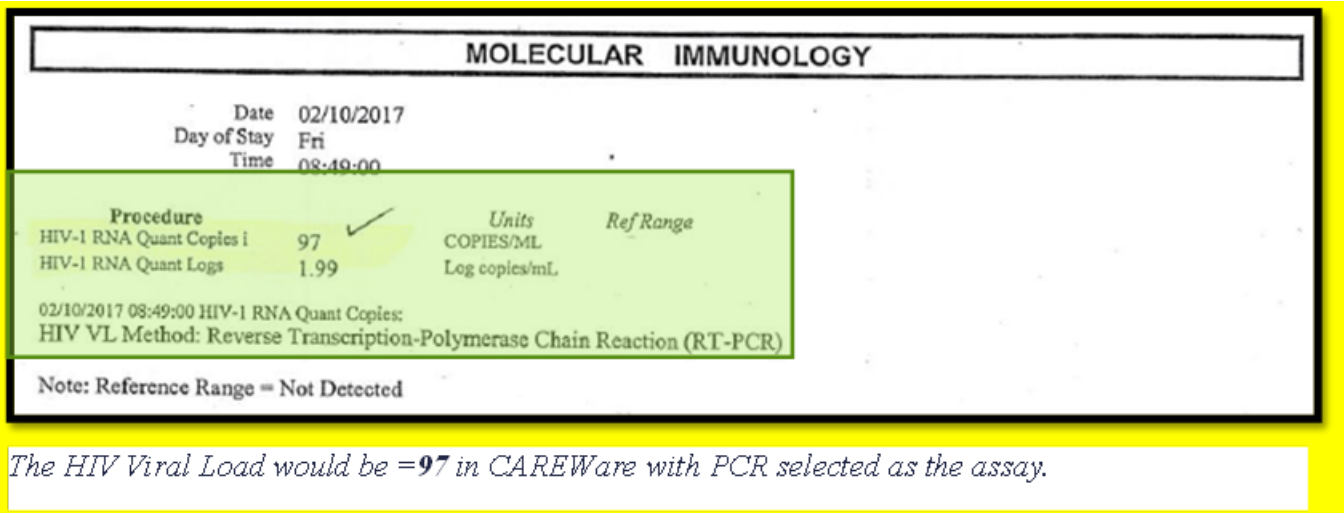
This test was performed using the COBAS(R) AmpliPrep/ COBAS(R) TaqMan(R) HIV-1 test kit version 2.0. (Roche Molecular Systems, Inc.)

****

PATIENT COMMENTS:

HIV-1 RNA Quant	48	Copies/mL	A	<20 NEG

The HIV Viral Load would be entered in CAREWare for this client as =48 with Other listed as the assay.



MOLECULAR IMMUNOLOGY

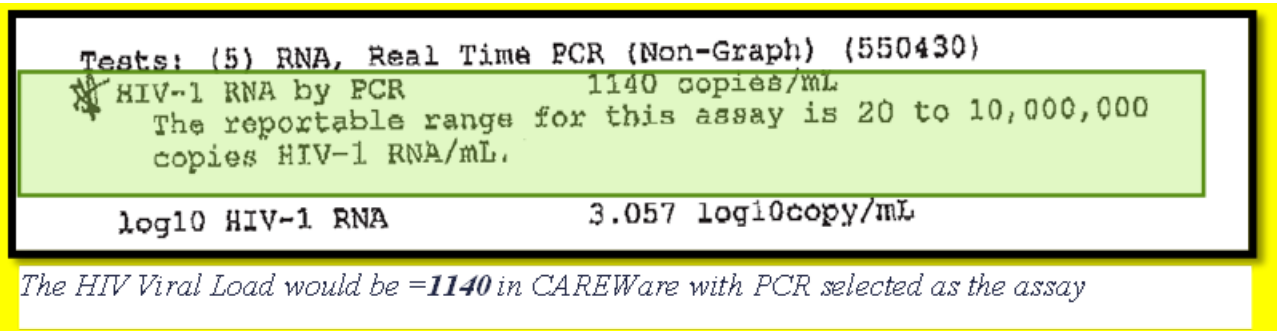
Date 02/10/2017
Day of Stay Fri
Time 08:49:00

Procedure		Units	Ref Range
HIV-1 RNA Quant Copies i	97	COPIES/ML	
HIV-1 RNA Quant Logs	1.99	Log copies/mL	

02/10/2017 08:49:00 HIV-1 RNA Quant Copies:
HIV VL Method: Reverse Transcription-Polymerase Chain Reaction (RT-PCR)

Note: Reference Range = Not Detected

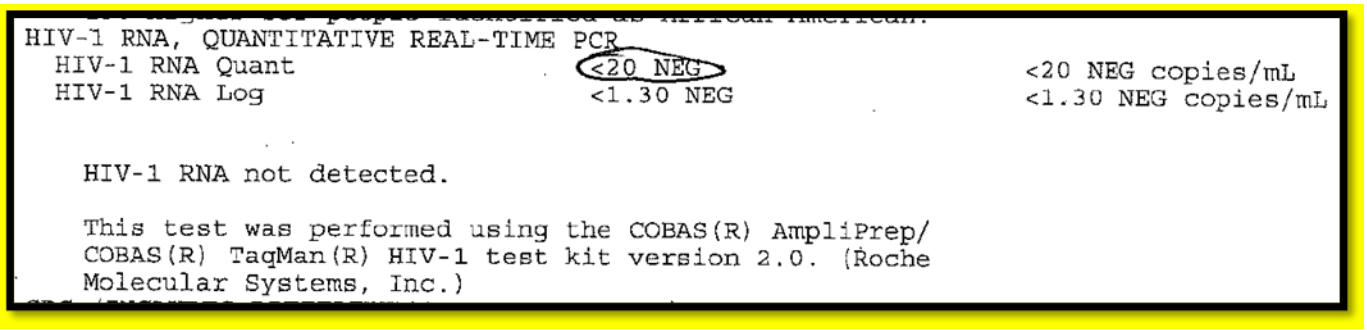
*The HIV Viral Load would be =**97** in CAREWare with PCR selected as the assay.*



Tests: (5) RNA, Real Time PCR (Non-Graph) (550430)
HIV-1 RNA by PCR 1140 copies/mL
The reportable range for this assay is 20 to 10,000,000 copies HIV-1 RNA/mL.

log10 HIV-1 RNA 3.057 log10copy/mL

*The HIV Viral Load would be =**1140** in CAREWare with PCR selected as the assay*



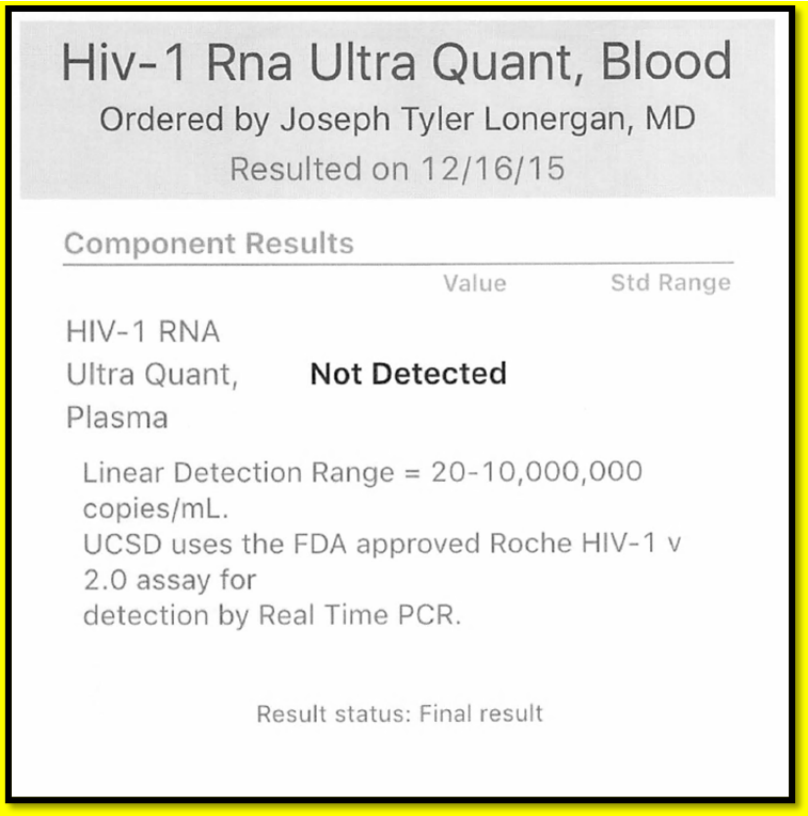
HIV-1 RNA, QUANTITATIVE REAL-TIME PCR

HIV-1 RNA Quant	<20 NEG	<20 NEG copies/mL
HIV-1 RNA Log	<1.30 NEG	<1.30 NEG copies/mL

HIV-1 RNA not detected.

This test was performed using the COBAS(R) AmpliPrep/ COBAS(R) TaqMan(R) HIV-1 test kit version 2.0. (Roche Molecular Systems, Inc.)

Another way you might see the HIV Viral Load is looking at the RNA Quant number. This means the quantity of HIV RNA per milliliter of blood specimen collected.



Hiv-1 Rna Ultra Quant, Blood

Ordered by Joseph Tyler Lonergan, MD

Resulted on 12/16/15

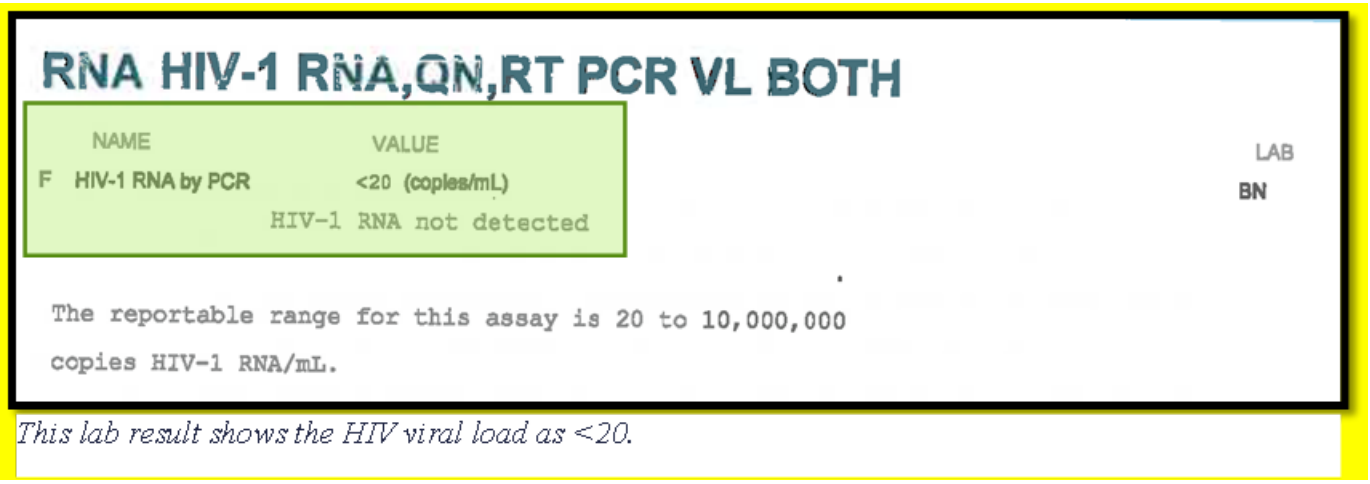
Component Results

	Value	Std Range
HIV-1 RNA Ultra Quant, Plasma	**Not Detected**	

Linear Detection Range = 20-10,000,000 copies/mL.
UCSD uses the FDA approved Roche HIV-1 v 2.0 assay for
detection by Real Time PCR.

Result status: Final result

This lab result is different in that the value is Not Detected – so the indication on what would be entered into CAREWare will come from looking at the detection range of 20 to ten million. Since the lower end of the range is 20, undetectable will be <20.



RNA HIV-1 RNA,QN,RT PCR VL BOTH

	NAME	VALUE	LAB
F	HIV-1 RNA by PCR	<20 (copies/mL)	BN
		HIV-1 RNA not detected	

The reportable range for this assay is 20 to 10,000,000 copies HIV-1 RNA/mL.

This lab result shows the HIV viral load as <20.

Component	Your Value	Standard Range	Flag
HIV Ag/Ab Combo Assay	Reactive	*Non Reactive*	A

Screen is POSITIVE for p24 antigen and HIV 1/O/2 antibodies.
The specimen will be sent for HIV-1/HIV-2 antibody differentiation confirmation by immunoassay.

This lab result is a qualitative immunoassay that detects the presence of a specific HIV antigen (Ag) and HIV antibodies (Ab). This is not a test that indicated quantitative viral load. This can be used for Proof of Diagnosis along with a document of detectable HIV RNA or a different assay that is not the HIV Ag/Ab Combo Assay.

Component Results

Component	Your Value	Standard Range	Flag
HIV 1/2 Ab Diff	See Below		

INTERPRETIVE INFORMATION: HIV-1/2 Ab Diff, Supplemental
This assay should not be used for blood donor screening, associated re-entry protocols, or for screening Human Cell, Tissues, and Cellular and Tissue-Based Products (HCT/P).

HIV Antibody	Positive	*Negative*	A
HIV 2 Abs, EIA	Indeterminate	*Negative*	A
HIV Interp	Pos HIV-1 Ab		A

1 This lab result is a qualitative immunoassay that detectes the presence of a specific HIV antibody (Abs). This is a lab test that tests for the presence of HIV-1 and HIV-2 antibodies. This can be used for Proof of Diagnosis along with a document of detectable HIV RNA or a different assay that is not the "HIV 1/2 Ab Diff."

HIV PANEL

Observations	Result	Reference / UoM	Date/Status
HIV-1 RNA Quant [1]	● 41	<20 NEG copies/mL Abnormal (applies to non-numeric results)	02/20/2017 04:37 am
HIV-1 RNA Log [1]	● 1.61	<1.30 NEG copies/mL Abnormal (applies to non-numeric results)	02/20/2017 04:37 am
Vendor note: This test was performed using the COBAS(R) AmpliPrep/ COBAS(R) TaqMan(R) HIV-1 test kit version 2.0. (Roche Molecular Systems, Inc.)			

The quantitative HIV Viral Load for this lab is =41.

	1 2/22/2017 1735	2 2/22/2017 0214	3 2/21/2017 0740	4 2/20/2017 1939	5 2/20/2017 1649	6 2/20/2017 1303
IMMUNOCHEMISTRY						
Vitamin B12 -True ...		1186 A				
Ferritin		1093.1 A				
Folate -Folic Acid		12.7				
THYROID TESTING						
TSH		0.910				
HEPATITIS TESTING						
Hepatitis A Virus ...			Negative *			
Hepatitis B Surfac...			Negative *			
Hepatitis B Core A...			Negative *			
Hepatitis C Antibody			Negative *			
INFECTIOUS DISEASE						
HIV 1/2 Ab Diff				See Below *		
HIV 2 Abs, EIA				Negative		
HIV Ag/Ab Combo Assay						Reactive *
HIV Antibody				Negative		
HIV Interp				HIV Abs Neg *		
HIV PRNA PCR Copy/Ml				2,400,000		
HIV RNA PRC Interp				Detected *		
HIV-1 RNA PCR log				6.4		
Influenza A 2009, ...	Not Detected *					
Influenza virus A RNA	Negative *					
Influenza virus B RNA	Negative *					
SEROLOGY						
Syphilis, Treponem...		Non Reactive *				
Stat C-Reactive Pr...					2.64 A	

This combination document can be used as Proof of Diagnosis and current viral load. The Proof of Diagnosis is determined from a detectable viral load of 2,400,000 (two-million, four-hundred thousand) and an immunoassay of the HIV Ag/Ab Combo Assay. You might notice that the individual is negative for the HIV Antibody test – this means that this sample was collected soon after infection and the body has not yet produced antibodies specific to HIV.

LYMPHOCYTE SUBSET PANEL 1			
%CD3(Mature T Cells)	67		57-85 %
Absolute CD3+ Cells		116 L	840-3060 Cells/uL
%CD4 (Helper Cells)		1 L	30-61 %
Absolute CD4+ Cells		3 L	490-1740 Cells/uL
%CD8(Suppressor T-Cells)		62 H	12-42 %
Absolute CD8+ Cells		112 L	180-1170 Cells/uL
Helper/Suppressor Ratio		0.02 L	0.86-5.00 Cells/uL
%CD16+CD56(NK Cells)	21		4-25 %
Absolute NK Cells		35 L	70-760 Cells/uL
%CD19 (B Cells)	12		6-29 %
Absolute CD19+ Cells		20 L	110-660 Cells/uL
Absolute Lymphocytes		174 L	850-3900 Cells/uL

The result to be entered into CAREWare is the Absolute CD4+ Cells value of =3.

Helper T-Lymph-CD4 CD4

	NAME	VALUE	REFERENCE RANGE	LAB
F	Absolute CD 4 Helper	543	359-1519 (/uL)	PDLCA
F	% CD 4 Pos. Lymph.	36.2	30.8-58.5 (%)	SE

The result entered into CAREWare is the Absolute CD 4 Helper value of =543

Tests: (1) Helper T-Lymph-CD4 (505008)
Order Note: Clinical Information: SRC:TH SRC:RT

*Absolute CD 4 Helper	[L]	20 x1000	359-1519
% CD 4 Pos. Lymph.	[L]	1.5 %	30.8-58.5
WBC		4.4 x10E3x1000	3.4-10.8
RBC	[L]	3.23 x10E6x1000	4.14-5.80
Hemoglobin	[L]	9.2 g/dL	12.6-17.7
Hematocrit	[L]	27.4 %	37.5-51.0
MCV		85 fL	79-97
MCH		28.5 pg	26.6-33.0
MCHC		33.6 g/dL	31.5-35.7
RDW		13.8 %	12.3-15.4
Platelets		379 x10E3x1000	150-379
Neutrophils		53 %	
Lymphs		29 %	
Monocytes		13 %	
Eos		4 %	
Basos		0 %	

The result for this lab result may seem odd but the result to be entered into CAREWare for CD4 is the Absolute CD 4 Helper value of =20. The x1000 is not necessary. You can tell that 20 is the correct answer because it is tagged with a [L] meaning it is a low result outside of the range; if it was 20,000 then it would be tagged with a [H].

Helper T-Lymph-CD4 CD4

COLLECTION DATE	02/03/2017	07/06/2016
Order Date	02/03/2017	07/06/2016
Result Date	02/05/2017	07/09/2016
Ordering Physician	DANKO, REKA	SPADONE, IVY
Immature Grans (Abs)	0.0 (0.0-0.1 x10E3/uL)	0.0 (0.0-0.1 x10E3/uL)
Immature Granulocytes	0 (%)	0 (%)
Baso (Absolute)	0.1 (0.0-0.2 x10E3/uL)	0.0 (0.0-0.2 x10E3/uL)
Hemoglobin	15.7 (12.6-17.7 g/dL)	15.2 (12.6-17.7 g/dL)
MCV	102 H (79-97 fL)	101 H (79-97 fL)
Eos (Absolute)	1.0 H (0.0-0.4 x10E3/uL)	0.6 H (0.0-0.4 x10E3/uL)
Absolute CD 4 Helper	1642 H (359-1519 /uL)	1190 (359-1519 /uL)
% CD 4 Pos. Lymph.	33.5 (30.8-58.5 %)	34.0 (30.8-58.5 %)

The results entered into CAREWare can be both of the Absolute CD 4 Helper entries. The first one on 02/03/17 for =1,642 and for 07/06/16 for =1,190.

CD4/T-HELPER CELL PROFILE
Result Date: 04/13/18 09:41 AM

Analyte	Result Value	Ref. Range	Units
WHITE BLOOD CELL COUNT	5.8	3.8-10.8	k/uL
LYMPHOCYTES	31.3		%
Lymphocytes	1899	850-3900	Cells/uL
CD4+,CD3+(Helpers)	675	490-1740	Cells/uL
CD4,CD3+(%Helpers)	36	30-61	%
CD8+,CD3+(Suppressors)	722	180-1170	Cells/uL
CD4/CD8 Ratio	0.94	0.86-5.00	ratio

Figure 1 – These results indicates the CD4+/CD3+ (Helpers) rather than the CD4+ alone. CD3s represent the total number of T lymphocytes. All T Cell Lympocytes (immune cells) have CD3 receptors on them but they can either have CD4 receptors or CD8 receptors. The result entered into CAREWare would be =675.

Grievance Protocol Guidance

Scope of Coverage
Directly applicable to all clients of RWPB in Nevada; all potential clients; and all Eligibility & Enrollment Specialists and other service providers for RWPB in Nevada.

Grievance Procedures
Clients will be offered a copy of the agency's grievance procedure at the time of eligibility application or agency intake process. An individual who feels they have a grievance regarding the Ryan White eligibility process has a right to have their grievance heard.

The first step to utilize the grievance procedure is with the service agency within the first thirty (30) days or depending on the grievance policy of the respective agency, whichever is shorter. It is appropriate to file a grievance only with the related agency (i.e., if a client has a pharmacy grievance, the grievance should be filed utilizing the pharmacy's grievance policy and procedure, not with a case worker uninvolved with the pharmacy).

If the grievance is not resolved at the agency level the client has the right to appeal to the respective Ryan White Recipient Office, which is the Office of HIV. Clients should try to resolve their conflicts at the agency-level; however, the Ryan White Recipient Offices have the responsibility to respond to any grievance submitted.

Introduction
The Nevada Ryan White Parts ABCD Programs have implemented a standardized universal protocol for agencies to develop and implement an agency-internal client grievance policy and procedure process. The following protocol and procedures are derived from a variety of sources with special recognition of one document.

The document titled, Client Grievance Procedures: A Mechanism for Assuring and Improving Quality of HIV/AIDS Care and Services, is a 1998 report that examines Client Grievance Procedures for Programs Funded Through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in the Boston Eligible Metropolitan Area (EMA).

Agency Requirements for their Internal Client Grievance Protocol

1. Procedures should aim to be user-friendly and written in clear and simple language, and particularly in the primary language of the clients served. *Consider updating the grievance protocol at least every two to five years, or when changes in organizational leadership occur.*
2. Clients and agency staff shall know the procedure exists and how to access it, with appropriate orientation and training for staff so that those responsible for implementing the grievance procedures have the necessary knowledge and skills.
3. The grievance procedure will provide a means of monitoring grievances and will enable the identification of potential system-wide service issues for resolution.
4. The grievance procedure will be required to clearly state: (1) the timeframes for clients to file a grievance with the agency (the whole process is not to exceed 30 calendar days); (2) how the client can file a grievance; (3) the steps in the grievance process; (4) agency personnel who are responsible to handle a grievance; (5) timeframes for the agency to respond to a grievance; (6) escalation steps for Recipient Office

involvement; (7) and accepted formats for communication between the client and agency (communications will be in writing or verbal, etc.).

5. The Nevada Ryan White Parts ABCD "Client Rights and Responsibilities & Grievance Principles" document is to be utilized by each agency. The form is to be collected by the eligibility provider during the enrollment/recertification process and uploaded to CAREWare as part of the client's annual eligibility packet.
6. Clients will be offered a copy of the agency's internal grievance policy and procedures during the intake process and at any time the client requests a copy.
7. The grievance process shall be applied consistently and impartially. *Agencies should never "retaliate" against a client who has submitted a grievance.*
8. In cases where clients are contesting the actions or behavior of agency staff, those individuals (identified agency staff and client) who are involved in the problem are also involved in crafting a solution.
9. Agencies shall utilize a standard, internally developed grievance form. This will enable the Recipient and funded agencies to track written grievances in a systematic manner.
10. The nuances of an agency's internal grievance procedure will be solution-oriented, so that it is unlikely to leave a grievance unresolved. *The procedure should at least include documenting the grievance, investigating the grievance (including acknowledging that it occurred), resolution (time frame), and documentation of the outcome.*
11. An agency's internal grievance procedure will focus on determining what is right, not who is right. The required grievance procedure shall be reviewed once every grant cycle by designated Recipient staff, funded agency program administrators, and by " clients." The process and the procedure will be revised if it is not working.

<u>Use of a Grievance Form</u>

Agencies shall develop and implement a standard grievance form, following this document's identified protocols, to be used to ensure that each grievance is described clearly and specifically.

- The following elements are required to be included on the internal grievance form: (1) date of grievance; (2) location of the grievance; (3) names of involved parties; (4) specific occurrences in relation to grievance; (5) steps already taken to resolve the grievance prior to the grievance being filed, including dates and parties involved; (6) steps made to reach a grievance resolution, including dates and parties involved; and (7) the final resolution reached. If the agency accepts verbal grievance filings, agency staff shall be required to complete a grievance form to keep a written record of the client grievance.
- The grievance form design will be accessible and easy to understand for all clients.
- The final grievance form and resolution is to be filed with the Recipient. This will assist the Recipient in monitoring the occurrence of written grievances at funded agencies, making the process more accessible and meaningful to clients, and protecting against potential agency retaliation against clients who file written grievances.
- Aside from the Recipient Office, client grievance filings may not be disclosed outside the agency without client consent.
- Information concerning clients who file grievances shall be kept confidential to lessen the potential, or perceived potential, of an agency's staff member retaliating against a client. Agencies are to limit disclosure within the agency to pertinent staff.

Timelines and Extensions

The entire internal grievance procedure should be completed as soon as possible and, in any event, within at least thirty (30) days from filing of the complaint. Extensions of deadlines may be necessary due to extenuating circumstances of staff or client illness or bad weather; generally, extensions should be disallowed in the interest of maintaining a responsive procedure.

Documentation, Communication and Follow-up of Grievance Resolution

At any point in the grievance process, if resolution is achieved to the client's satisfaction, detailed documentation of the resolution and its provisions should be provided in writing. The client should be given an opportunity to review, comment on, and approve finalization of the resolution. A copy of all documents related to the grievance should be kept in a file separate from the client's general service file and the final resolution should be sent to the Recipient office. The setting of a future "check-in date," at which parties involved in provisions or next steps confirm that they have been fulfilled, is also recommended to assure accountability.

Centralized grievance tracking and review within an Agency

The Ryan White Parts ABCD requires that agencies implement a system for tracking grievances and reviewing them on a regular basis as a management tool for quality improvement. Such tracking and review are to be conducted in keeping with HIPAA regulations. Agencies should minimally review the numbers and types of grievances filed and the nature of the resolutions at least once each year.

Recipient Office Involvement

The Recipient Office has no intention of intervening in an agency's handling and resolution of a filed grievance to the extent to which it is developed and managed in accordance with this guidance. It is understood that occasional grievance filings are part of a natural system of ongoing quality gap identification and resolution that every agency may experience from time to time. However, the Recipient Office maintains the right to intervene in an agency's quality assurance program when a preponderance of client-filed grievances occurs. If requested by the Recipient Office, the agency shall be prepared to send the Recipient Office a client's original client grievance form and copies of any supporting documentation for review and resolution. If a client is unsatisfied with the outcome of the grievance at the Agency level a notice of appeal can be sent to the Recipient Office for review.

Appendix A: Examples for an Agency's Internal Grievance Procedure Steps (not required language)

- Initial or Informal Complaint: An initial complaint is brought either verbally or in writing to the attention of the program staff member, who is either the subject of the complaint or is responsible for the programmatic area that is the subject of the complaint. The contacted staff member will record the date of the complaint and a description of the complaint in the client's records. The staff member should attempt to resolve the complaint as soon as possible, no later than three (3) business days from the date of the complaint. The staff member should record the dates and details of agency attempts to resolve the complaint in the client's records. If the complaint is resolved to the client's satisfaction, no further action is required. The staff member must record the date and the details of the resolution in the client's records.

- Written Grievance: If the complaint is not resolved to the client's satisfaction, the staff member shall inform the client of the right to file a written grievance. The staff member should offer the client assistance by explaining the agency's grievance procedure, filling out the grievance form, and/or obtaining translation services, as needed, to ensure that the client understands the procedure. At this juncture, a copy of the written grievance shall be provided to the client to retain, and a copy shall be retained by the agency.
- Attempt to Resolve Grievance: The use of a designated staff person to broker the resolution is recommended. Staff shall record the dates and details of meetings to resolve the complaint in the client's records. This second attempt at resolution should be completed within five (5) business days of the filing of the written grievance. After five (5) business days, the grievance would move to the next level.
- Resolution Detailed in Writing: If the grievance is resolved to the client's satisfaction, detailed documentation of the resolution and its provisions shall be provided in writing to the client. The date and details of the resolution should be noted in the resolution documentation. A copy of the resolution shall be sent to the Recipient Office.
- Grievance Process to Next Internal Resolution Level(s): If the grievance is not resolved to the client's satisfaction, or five (5) business days pass without resolution, the grievance should be formally directed to the next appropriate management level and a designated staff member. The next management level could be one of the following: the Program Director, the Clinical Director, Administration, the Assistant Director, or the Executive Director. Whatever the case, the internal grievance procedure should delineate the steps in the agency management structure through which a grievance travels.
- Final Internal Grievance Resolution Level: Depending on the agency, the appeal process may continue through the management structure as appropriate. Generally, the Executive Director should have the final decision-making responsibility for resolving grievances through the internal procedure. At some agencies, or if the Executive Director is the subject of a grievance, it may be appropriate to have the Board of Directors serve as the final decision-making body.
- *Notice of Appeal: If the grievance escalated through the management structure of the agency unresolved, the grievance should be directed to the Recipient Office for additional follow-up. The Recipient Office, in partnership with the agency, will make every effort to resolve the issue in a fair and expeditious manner. If the grievance is unable to be resolved at the Recipient Office level, this should be documented. All contacts (phone, email, in-person) should be carefully documented, as well as all attempts made to find a viable solution for the client. The Recipient Office will collect data relating to grievances and assess that data annually to ensure the provision of high-quality services.*

Nevada Ryan White Part B Guidelines – Federal Poverty Level

RWPB has adopted the 2024 Federal Poverty Level guidelines.
Some State programs including Welfare delay adoption until April 1. Clients below 138% of the FPL should still be directed to Welfare to apply for eligibility determination. Please ensure that whenever there is a change in health insurance or medical benefits that it is communicated back to the NMAP Provider.

Monthly

Household/Family Size	100%	133%	138%	150%	200%	250%	300%	400%
1	$1,255	$1,669	$1,732	$1,883	$2,510	$3,138	$3,765	$5,020
2	$1,703	$2,265	$2,351	$2,555	$3,407	$4,258	$5,110	$6,813
3	$2,152	$2,862	$2,969	$3,228	$4,303	$5,379	$6,455	$8,607
4	$2,600	$3,458	$3,588	$3,900	$5,200	$6,500	$7,800	$10,400
5	$3,048	$4,054	$4,207	$4,573	$6,097	$7,621	$9,145	$12,193
6	$3,497	$4,651	$4,825	$5,245	$6,993	$8,742	$10,490	$13,987
7	$3,945	$5,247	$5,444	$5,918	$7,890	$9,863	$11,835	$15,780
8	$4,393	$5,843	$6,063	$6,590	$8,787	$10,983	$13,180	$17,573

Annual

Household/Family Size	100%	133%	138%	150%	200%	250%	300%	400%
1	$15,060	$20,030	$20,783	$22,590	$30,120	$37,650	$45,180	$60,240
2	$20,440	$27,185	$28,207	$30,660	$40,880	$51,100	$61,320	$81,760
3	$25,820	$34,341	$35,632	$38,730	$51,640	$64,550	$77,460	$103,280
4	$31,200	$41,496	$43,056	$46,800	$62,400	$78,000	$93,600	$124,800
5	$36,580	$48,651	$50,480	$54,870	$73,160	$91,450	$109,740	$146,320
6	$41,960	$55,807	$57,905	$62,940	$83,920	$104,900	$125,880	$167,840
7	$47,340	$62,962	$65,329	$71,010	$94,680	$118,350	$142,020	$189,360
8	$52,720	$70,118	$72,754	$79,080	$105,440	$131,800	$158,160	$210,880

Vital Status Request Policy

If a RWPB subrecipient needs an official confirmation of a client's vital status (i.e., deceased), a "Vital Status Request" form can be completed and submitted to NVRWPB@health.nv.gov. RWPB staff will have three (3) business days to respond to the subrecipient with an official confirmation.

If subrecipients have documentation confirming that a client is deceased, the following steps should occur:

- Upload Acceptable Documentation (please see listed below) of deceased client's status into CAREWare.
- Change client's status in required areas (CAREWare & Liberty Dental portal)

Acceptable documentation can consist of the following:

- Copy of death certificate
- Bureau of Vital Statistics record
- Doctor's statement
- Veteran's Affairs or Military service record
- Indian Health Services, Bureau of Indian Affairs or Tribal records
- Statement from funeral director
- Records from hospital or other institution where the person died

- Insurance company records
- Information obtained by Investigations and Recovery and/or Child Support Enforcement
- Newspaper death notice listing survivors
- State or local assistance records (including burial payment records)
- Lodge, club, or organization records
- Police records
- Social Security claim number or evidence of receipt of survivor's benefit from deceased person's Social Security Number

If subrecipient does not have official confirmation of client being deceased subrecipient will:

1. Complete a "Vital Status Request" form and email it to NVRWPB@health.nv.gov
2. When sub-recipient receives completed "Vital Status Request" form from RWPB, if client is deceased subrecipient will:
    a. Upload official confirmation of client's (deceased) status into CAREWare
    b. Change client's status in required areas
3. If client is not deceased, sub-recipient ensures that client is still active in all required areas, up to and including referral to lost-to-care or retention-in-care non-medical case manager(s)

Upon receiving "Vital Status Request" form RWPB will:

1. Check Nevada State Directory for client's vital status; and/or
2. Return secure email to sub-recipient's informing them of client's vital status.

SECTION III: NEVADA MEDICATION ASSISTANCE PROGRAM (NMAP)

Ryan White and NMAP

Nevada Medication Assistance Program (NMAP) is a service provided under the Ryan White program. It is designed to provide medication to clients who do not have other, reasonable means. Reasonable means, in most cases, include forms of insurance that will pay for, or reduce the cost of medication. All clients who are NMAP eligible are also Ryan White eligible, but not all Ryan White clients are NMAP Eligible.

Ryan White serves as the payer of last resort for all services. NMAP acts as the payer of last resort for medication. NMAP can assist with covering co-pays and premium costs to help supplement some insurance plans. When a client has insurance that covers all medication costs, such as Medicaid/Some Medicare plans, then there is no need for NMAP as there is nothing else for the service to cover.

Income

Because NMAP is a Ryan White service it shares the need for proof of income. The one addition to this is that NMAP requires the most recent 30 days of income at the time of referral. If a client is referred to NMAP at same time they complete their eligibility, then the income documentation they provided is sufficient.

If a client is referred to NMAP at any other point in their eligibility, they will need to provide their most recent 30 days of income to ensure the client is eligible. This should be submitted as an attachment in the referral.

Health Insurance

Background

The Nevada Medication Assistance Program (NMAP) provides the best care and medication coverage possible for clients. To that end, NMAP funds Health Insurance to Provide Medications financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical prescriptions under a health insurance plan. This includes:

- Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low-income clients that provide a full range of HIV medications;
- Paying prescription drug co-pays and deductibles on behalf of the client;
- Providing funds to contribute to a client's Medicare Part D True Out-of-Pocket (TrOOP) costs;
- Paying for or reimbursing clients for their copays attached to employer insurance plans; and
- Paying Cobra premiums on behalf of a client.

Open Enrollment

From November 1st through January 15th the NMAP program offers a chance for people who do not qualify for other forms of insurance, such as Medicaid, Medicare, or employee sponsored insurances, to sign up for Affordable Care Act (ACA) Plans. These plans are selected based on those available through Nevada Health Link. Citizens and documented immigrants are able sign up for these plans through Nevada Health Link itself. Undocumented immigrants can sign up through a broker for certain plans that do not require a Social Security Number (SSN). Access to Healthcare Network (AHN) directly assists in the signing up of clients for plans.

Instructions:
Before the November 1st start to Open Enrollment, the NMAP program will work with subrecipients to identify clients who are either uninsured or need to renew their ACA plans. Once these lists are distributed, subrecipients will be expected to reach out to these clients to strongly encourage them to sign up for an Open Enrollment period. Clients will be able to sign up for these appointments through a portal on the Office of HIV website.

Clients will then be given an appointment time to meet with a Health Insurance Specialist (HIS). The HIS will go through options with the clients to select a plan. Once a plan is selected, they will submit the sign-up through the Nevada Health Link website, or to a broker in the case of undocumented immigrants. Coverage will start either January 1st of the following year, or February 1st depending on when the client signs up.

Please note plans can only be purchased for the client and not anyone else in their household.

Marketplace Insurance Special Enrollment Periods
A Special Enrollment Period (SEP) lets an eligible individual enroll in a new health plan or change plans outside of the Open Enrollment Period. Certain special circumstances, or life events, may make someone eligible to enroll or change plans within 60 days of the life event. Life change events, such as marriage or a change in income, may affect a client's Advance Premium Tax Credits or cost-sharing reductions under a qualified health insurance plan.

Common examples of life events:

- Marriage
- Birth
- Death, divorce, or legal separation from a spouse
- Loss of job, reduction in work hours, or quitting a job
- A change in eligibility for an employer plan or a significant change in the plan options
- Loss of Medicaid or Children's Health Insurance Plan coverage
- The end of COBRA coverage
- A change in immigration status by becoming a U.S. citizen or lawful resident
- An increase or decrease in income
- Release from incarceration

Instructions
As needed, please refer to the imbedded document by the Affordable Care Enrollment Technical Assistance (ACE TA) Center to review the Special Enrollment Periods below. Clients who meet the requirements for a SEP should be referred to the Marketplace or a client enrollment Broker as soon as possible to facilitate updating his/her account information and enroll/change plans, as needed.

nevada health link

Did You Miss the Opportunity to Enroll in a Qualified Health Plan Through Nevada Health Link?

Although the Open Enrollment Period to enroll in coverage ended, you or a loved one may be eligible to enroll now if you've recently experienced a qualifying life event.

Special Enrollment Periods (SEP) allow for health insurance enrollment any time during the year. Open Enrollment runs from November 1 - January 15, but you may enroll in a Qualified Health Plan if you've had a recent Qualifying Life Event (QLE).

Qualifying Life Events:

- **Loss of Health Coverage:** You or anyone in your household lost qualifying health coverage. You may report a loss of coverage up to 60 days before the loss of coverage.
- **Change in Household Size:** You got married, divorced, or legally separated and lost health insurance. Or, if you had a baby, adopted a child, or placed a child for foster care or adoption.
- **Change Your Place of Residence – Moving:** You or anyone in your household had a change in your primary place of living and moved to a new service area, gaining access to a new qualified health plan.
- **Other Qualifying Life Events Include:**
  - Gaining U.S. Legal Status
  - Experience other changes that may affect your income and household size
  - Change of immigration status
  - Release from incarceration (prison or jail)
  - American Indian/Alaska Native can enroll in an SEP anytime
  - Change in income making current off-exchange health plan unaffordable

Important: If you're enrolling in Marketplace coverage for the first time, you may need to submit documents to confirm that you qualify for this Special Enrollment Period.

**Certain restrictions apply for Qualifying Life Events (QLE). Call or click to see if you qualify.*

Call: 1-800-547-2927 | Email: CustomerServiceNVHL@exchange.nv.gov | Visit: NevadaHealthLink.com

Tax Reconciliation Policy

Background
The premium tax credit is a tax credit that NMAP requires all eligible persons who buy health insurance through a state or federally facilitated Marketplace/Exchange to claim in its entirety. The premium tax credit can be received in one of two ways: 1.) advance payments of tax credits paid directly to the health insurance company to reduce a monthly insurance premium; or 2.) as a lump sum payment provided at the end of the year when filing federal income taxes.

NMAP requires all eligible persons, who receive health insurance premium payment assistance, to receive premium tax credits in advance to lower the health insurance plan's monthly premium they are required to pay.

At the end of a calendar year, filing federal income taxes helps the Internal Revenue Service (IRS) and Health Insurance Marketplace determine if an individual enrolled in a Marketplace plan received the correct amount of premium tax credits. If the individual received too many premium tax credits, then the individual may owe money on their federal income taxes to the IRS, called a liability, to pay back the overpayments of the premium tax credits. If the individual received too few premium tax credits, then the individual may receive money from their federal income taxes from the IRS, called a refund.

Note: When a client, who receives health insurance premium payment assistance from NMAP, receives premium tax credits inadequate to cover the premium cost, NMAP must pay higher monthly premiums to the client's Marketplace health insurance company. As a result, when the client files federal income taxes they may receive a refund from the IRS. NMAP will work with Access to Healthcare Network (AHN) to vigorously pursue part of the client's tax refund that was due to overpayments of the health insurance premium.

Individuals may be eligible for a premium tax credit if they meet ALL the following requirements:

- Buys health insurance through the Marketplace/Exchange
- Is NOT eligible for coverage through employer or government plans (e.g. Medicare and Medicaid)
- Is between 100-400% of the Federal Poverty Level (FPL)
- Cannot be claimed as a dependent by another person
- Files federal income taxes on IRS Form 1040
    - Clients are REQUIRED to file IRS Form 1040 (federal income tax) annually to reconcile advance premium tax credits even if you would not normally be required to files taxes due to income or age.

Instructions

Annually
Access to Healthcare Network (AHN) Eligibility and Enrollment Specialists will assist clients with Marketplace plan selection into a NMAP approved Marketplace plan.

Outside of the Open Enrollment Period
Eligibility and Enrollment Specialists will periodically review the Marketplace Special Enrollment Periods to see if the client is eligible to join and/or switch plans outside of the Open Enrollment Period; see Health Insurance section above If any change in circumstances occur, it is recommended that clients or Eligibility and Enrollment Specialists notify AHN of any changes that could affect premium tax credits. *Changes in premium tax credits can affect clients' tax refund or liability. Failure to contact AHN about changes to your status could result in delayed payments, suspended access, and even termination of plans.*

During tax season, January 31 through April 15
AHN, in partnership with NMAP, will draft and sent clients who receive premium payment assistance a letter informing them that they must file federal income taxes prior to April 15th each year. The letter, generated by AHN, will include instructions and information for clients to send a copy of their tax form 8962 to the AHN office and ways to pay for premium overpayments that resulted in a client tax refund.

Clients who request assistance and a voucher for the contracted tax service to have their tax return processed and determine if any underpayment or overpayment is received. Clients are then responsible for returning their tax form 8962 to AHN for their review to see if clients received premium tax refund or liability.

- If the client is issued a tax refund due to a premium tax credit overpayment, AHN will inform the client that payment must be made to NMAP for the portion of the refund due to the premium overpayment.
- If the client owes a tax liability, AHN will inform the client that NMAP can make a payment on their behalf to the IRS for the portion of liability due to a premium underpayment. The client will still be responsible for any remaining tax liability payments.
- Under no circumstances can NMAP funds be used to pay the federal penalty for not having health insurance coverage, called the Minimum Essential Coverage fee, or any other tax liability owed by the client that is not directly related to the reconciliation of the premium tax credit.

IRS Tax Documentation
Appropriate tax documentation that shows the client's net premium tax credit can be found on the following forms.
**Please keep in mind that if clients file taxes electronically, IRS Form 1040 will automatically include a completed IRS Form 8962. If clients file taxes manually, clients will have to include IRS Form 8962 with their Form 1040 and manually fill in IRS Form 8962 using IRS instructions.

- IRS Form 1040- Federal Income Tax Return
    - Client received more premium tax credit than allowed and owes money: "Excess advance premium tax credit repayment" (tax and credits section)
    - Client received less premium tax credit than allowed and is due a refund: "Net premium tax credit" (payment section)
    - See Appendix A

- IRS Form 8962- Premium Tax Credit

- Client received more premium tax credit than allowed and owes money: "Excess advance premium tax credit repayment" (line 29)
- Client received less premium tax credit than allowed and is due a refund: "Net premium tax credit" (line 26)
- See Appendix B

Documentation of Reconciliation Actions

Documentation of vigorous pursuit is a state and federal requirement of NMAP. Two (2) attempts must be made to contact the client to pursue any excess tax refund due to the overpayment of health insurance premiums. All efforts to contact clients will be recorded in CAREWare within the client's file. All contact attempts must be completed by July 31st; exceptions will be made for clients who file taxes in April or request an extension from the IRS and notify NMAP. Each contact attempt should not be made within the same business week, but rather spaced apart to give clients the ability to respond.

Procedures

1. Not later than January 31 of each year, clients will be notified, that federal income taxes must be filed by April 15th for the previous tax year. Information will be provided for free/low-cost tax filing assistance, see Other Services – Taxes section of Common Guidance. The information will also remind clients of the need to send a copy of their filed IRS tax form 8962 to AHN for review. Notifying the client of this information will count as vigorous pursuit attempt #1.
    - CAREWare will be updated to reflect the method of contact and the date of notification.
2. Within 60 calendar days of filing IRS federal income taxes, NMAP assisted clients are required to provide proof of tax documents to AHN. AHN will review clients' received tax documents for premium tax credits to determine if clients have excess premium tax credits and therefore owe money to NMAP, or if clients have net premium tax credits and therefore NMAP will pay a tax liability to the IRS.
    - CAREWare will be updated to reflect the date NMAP received tax documents and documents will be uploaded into the system.
3. AHN will notify the client of the outcome of the tax document review and how much money is either owed to NMAP by the client because of a tax refund or owed to the IRS by NMAP for a tax liability. Notification will include information about the timeline to pay NMAP if a tax refund was received by the client.
    - CAREWare will be updated to show the date the client was notified, the method of contact, the outcome of the review, and the amount owed.
4. If the client has not sent in payment for a tax refund owed, AHN will make another attempt to receive payment from the client. This will count as vigorous pursuit attempt #2.
    - CAREWare will be updated to reflect the date and method of contact for each attempt.

5. After two (2) attempts at contacting the client, the documentation of vigorous pursuit is complete, and no more action needs to be taken.

Refund owed to the client by the IRS
AHN will notify the client of the outcome of the tax document review and how much money is either owed to NMAP by the client because of a tax refund or owed to the IRS by NMAP for a tax liability. Notification will include information about the timeline to pay NMAP, acceptable method of payment, and where to send the payment. NMAP will track all payments to the IRS and from the client for compliance with HRSA PCN 14-01.

Note: *If a tax refund was received by the client and a HIP overpayment determination was made, the client will be requested to provide payment within* 90 calendar days *upon receipt of notice. Clients can request a* Financial Hardship Waiver *by writing a letter to NMAP with an explanation of the financial hardship. All documentation is required to be uploaded into the client's file in CAREWare.*

Per PCN 14-01 "Recovered excess premium tax credits are considered insurance refunds, not program income. As such, grantees must use recovered excess premium tax credits in the HIP and Cost Sharing Assistance service category in the grant year in which the refund was received."

Primer on Ryan White Dental Insurance Enrollment

Purpose of Primer

To assist with correct and secure submission of client dental insurance enrollment forms from subrecipients to the State of Nevada Office of HIV. This document will serve as a step-by-step instruction guide for uploading confidential client enrollment forms to a secure website so the Office of HIV can enroll these clients with Liberty Dental, the provider of our dental program insurance.

Background

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/ Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use Ryan White HIV/AIDS Program (RWHAP) funds for standalone dental insurance premium assistance, a RWHAP Part B recipient must implement a methodology that incorporates the following requirement:

- RWHAP Part B recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

Clients and Liberty Dental Documentation

If a client has a mailing address, then their documentation should be sent to the address listed on the application. If a client needs their documentation sooner, then the case manager or backup with access to the Liberty Dental website should print out the necessary ID card and documentation to ensure the client can get the care they need. This should be done in the case of an upcoming dental appointment, emergency dental need, or unhoused client with no mailing address.

Unhoused Clients

It is the responsibility of the subrecipient to ensure clients get copies of their Liberty Dental documentation. If a client is unhoused with no mailing address, then the subrecipient must arrange for the client to receive their ID card and other necessary documentation. This should occur when a client is being signed up for the insurance and before they leave their appointment, or when they come in to put a wet signature on their applications. Emailing the documentation to the client is also acceptable.

Process

Step 1. Eligibility Specialists will fill out the Dental Insurance Enrollment Form as part of the Universal Eligibility packet for those clients enrolling in dental coverage. Please view the Sample Demographic Field below then view the Form Requirements in order to correctly complete step 1 of the Dental Form.

Enrollment Process:

Completed dental insurance enrollment forms must be uploaded to CAREWare Part B. If you are unable to upload the application directly, forward the completed form to your partner organization. (Please refer to the Ryan White Part B Primer 19-08A for details.)

Please Note: **Existing clients do not need to wait to have their Time Slice updated in the Liberty Dental system. Only newly enrolled or clients returning to care need to follow the rules regarding date of submission below**

- New and returning-to-care enrollments submitted **by** the 20th of the month will have a start date of the first (1st) of the following month.
- New and returning-to-care enrollments submitted **after** the 20th of the month will have a start date of the first (1st) of the second month following.
  - For example: New Applications submitted by January 20th will have a start date of February 1st; New applications submitted after January 20th will have a start date of March 1st.
- Enrolled clients will receive their dental insurance cards via US mail.

Emergency Dental:

If emergency dental services are needed (as defined by this link https://medical-dictionary.thefreedictionary.com/dental+emergency), be sure to check the Emergency Dental Request box on the form below and type **"Emergency Dental Insurance Request"** in the subject line of the email. Emergency requests will be addressed within two (2) business days. Please note that RWPB is the payer of last resort and any other dental insurances will be billed first.

This form is part of the Eligibility Packet and must be uploaded into CAREWare.

- 20th and before start the first of the next month
  - Application Date – 20th June
  - Eligibility Start Date – 1st July
- 21st and BEYOND start the first of the month after the next
  - Application Date – 21st June
  - Eligibility Start Date – 1st August
- Emergency Request start the 1st of the current month.
  - Application date - 13th June
  - Eligibility Start Date – 1st June

Current Ryan White Eligibility	**Start Date: 01/01/2019**		**End Date: 06/01/2019**
Eligibility Specialist Name: SARA SMITH			**Direct Phone Number: (775)-123-4567**
Client Legal Last Name: COOK	**Client Legal First Name: JOHN**		**Gender: MALE**
URN: JHCO0102831U	**Emergency Dental Request (see above note):** ☐ Yes		
Date of Birth: 01/02/1983	**Phone Number: (775)-456-7890**		
Language Preference: ☒ English ☐ Spanish ☐ Other:	**SSN or TIN*:** 000-00-0000		
Home Address: 123 WATER DR.	**City:** RENO	**State:** NV	**Zip:** 89512
Mailing Address** *(if different than home):* 456 AIR LANE	**City:** RENO	**State:** NV	**Zip:** 89511

Each category must be filled in except, when applicable, the Emergency Dental Request. Please fill this category in only if it is an emergency request. The SSN or TIN category will be used for verification of other health benefits. This category may be left open if the client does not have an SSN or TIN.

Dental Form Requirements

Field Name	Requirement	Format
Start Date	Yes	00/00/0000 (month/day/year)
End Date	Yes	00/00/0000 (month/day/year)
Eligibility Specialist Name	Yes	First & Last Name
Direct Phone Number	Yes	(area code)-000-0000 ext. 0000
Client Legal Last Name	Yes	All Caps
Client Legal First Name	Yes	All Caps
Gender	Yes	All Caps
URN	Yes	All Caps
Emergency Dental Request	No	Check Box if Needed
Date of Birth	Yes	00/00/0000 (month/day/year)
Phone Number	Yes	(area code)-000-0000 ext. 0000
Language Preference	Yes	Check Box
SSN or TIN*	Yes, if client has one	SSN: 000-00-0000 TIN: 00-0000000
Home Address	Yes	All Caps
City	Yes	All Caps
State	Yes	All Caps
Zip	Yes	00000
Mailing Address	Yes	All Caps
City	Yes	All Caps
State	Yes	All Caps
Zip	Yes	00000

Step 2. In order to complete step 2 of the Dental Form the client must read the form, check the boxes and sign the form.

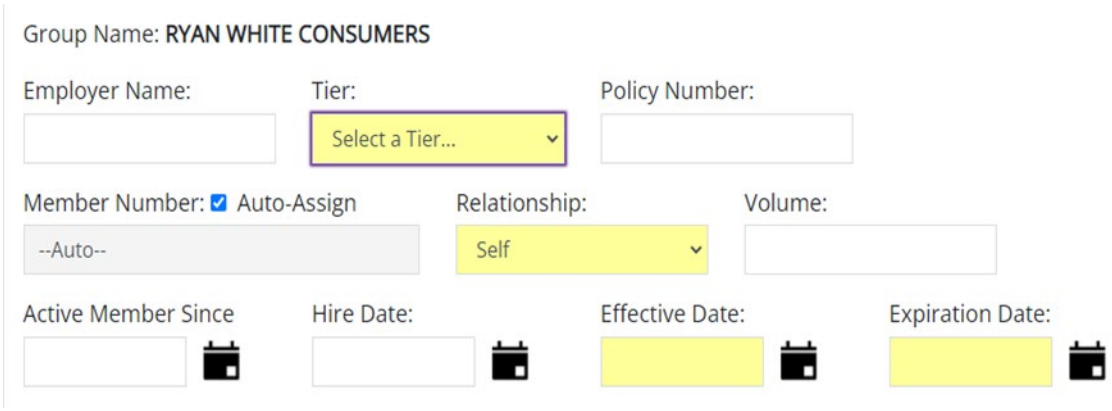
Please check all boxes below showing that you understand and agree to the following program requirements:

- ☐ I understand that in order to receive dental services I will complete my annual certification and re-certification in the time frame established by the Ryan White Program in order to remain eligible for dental services.
- ☐ I understand that in order to receive dental services I must have one (1) dental prevention service every six (6) months.
- ☐ I understand that failure to receive one (1) dental prevention service every six (6) months may lead to discontinuation of dental services.
- ☐ I fully understand that by completing this form, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Ryan White Part B Program.
- ☐ I understand this information will be kept confidential but will be used by staff to review my eligibility for this program.
- ☐ I fully understand that by signing this form, it is my responsibility to ensure any, and all procedures are covered prior to procedure being completed or I may be liable for all cost associated with uncovered procedure.
- ☐ I fully understand that by signing this form, I have the right to request a prior approval letter for all procedures to ensure coverage.

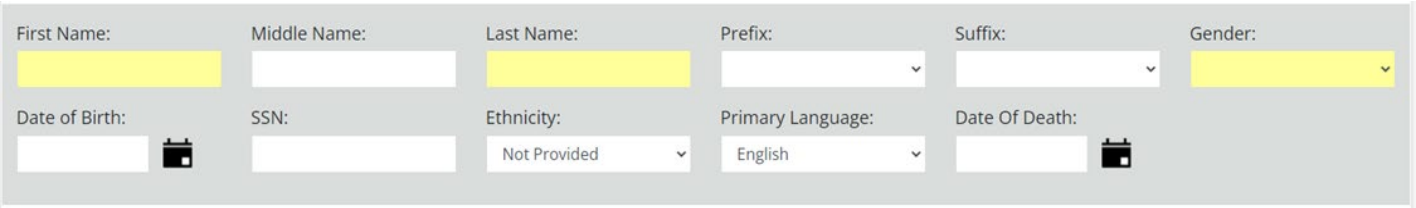
Client Signature: Date:

Step 3. Add/Update client's information in the Liberty Dental Portal

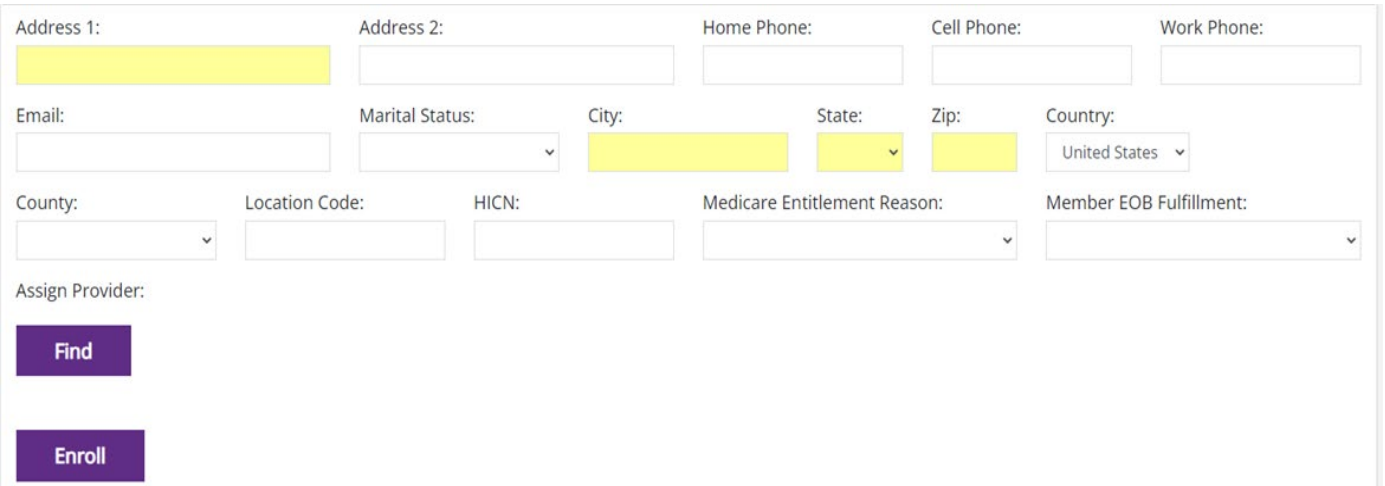
- Start enrollment process.
- Client that has never been RWPB Liberty Dental.
- Summary of Benefits – These are benefits offered by Liberty Dental.



- Tier – Employee only
- Member Number – uncheck auto-assign and use Ryan White URN
- Relationship – Self
- Effective Date – Liberty Dental current plan Effective Date
- Expiration Date - Ryan White Eligibility End Date



- First Name – Legal First Name
- Last Name – Legal Last Name
- Gender – Client identifies



- Address 1 - Address where client receives mail.
- City – City where client receives mail.
- State - Where client receives mail.
- Zip – Zip code where client receives mail.
- Enroll – Enroll client in Liberty Dental insurance plan.

- SSN# - Do not use
- Subscriber – Use Ryan White URN
- AS of Date – (can be left blank) Uses that date to search for active plans as of that date.
- Last Name - Search by Last Name

- View – Select to update client details.

Profile	Group Number	Subscriber Number	Last Name	First Name	DOB	Add Dependent	Terminate Coverage	Switch Group
View	RW0001	RCBL08171U	Balboa	Rocky	08/17/1999	add	terminate	switch
View	RW0001	RCBL08171U	Balboa	Rocky	08/17/1999	add	terminate	switch

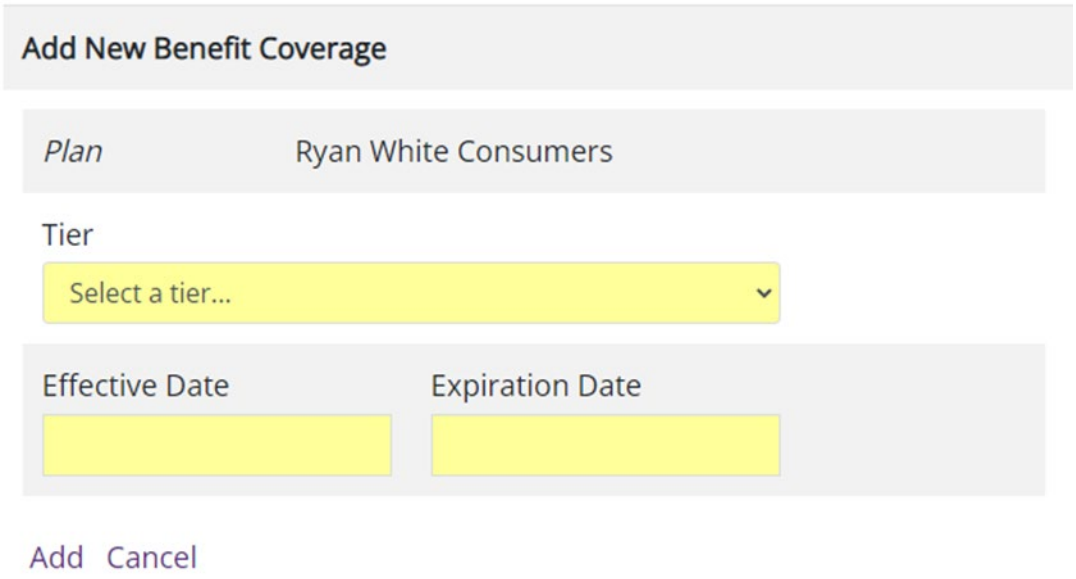
Group	RYAN WHITE CONSUMERS			
Plan	Ryan White Consumers			
Tier	Employee Only	*Tier as of Date*	5/1/2021	Change Tier
Effective Date	5/1/2021	*Expiration Date*	8/31/2022	Update Time Slice
Member Number	RCBL08171U	*Policy Number*	N/A	Add Benefit Coverage
Term. Reason				
Subscriber Number	RCBL08171U			

- Change Tier – Not used
- Update Time Slice – Updating current clients whose eligibility has not expired (six-month eligibility or annual certification)
- Add Benefit Coverage – For clients who have fallen out of care and are returning

Coverage

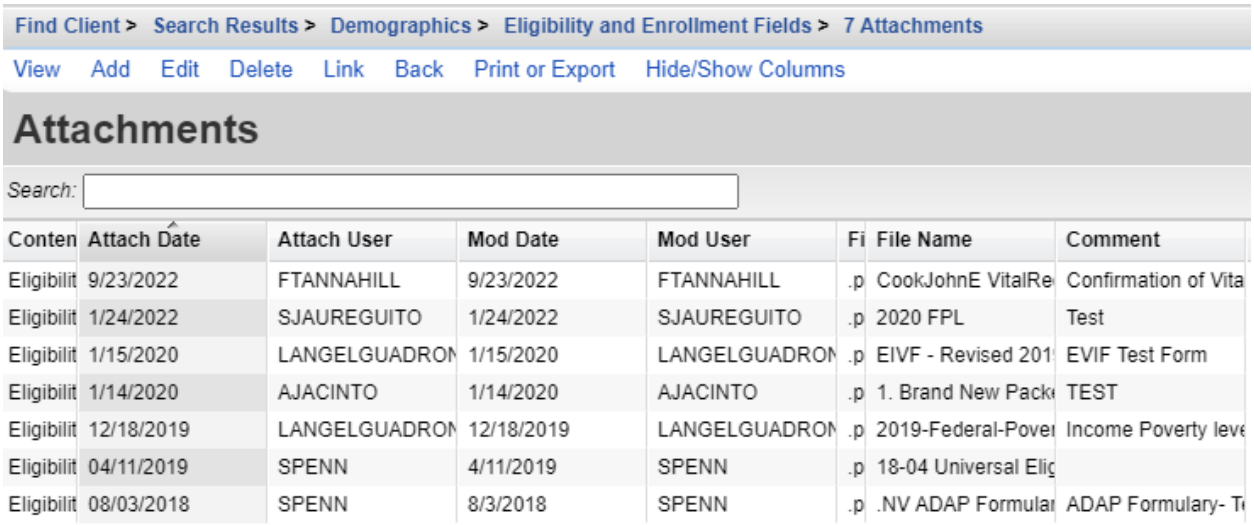
Group	RYAN WHITE CONSUMERS		
Plan	Ryan White Consumers		
Tier	Employee Only	*Tier As of Date*	12/1/2021
Effective Date *mm/dd/yyyy*	12/1/2021	***Expiration Date*** *mm/dd/yyyy*	5/31/2022
Term. Reason	none		

- Effective Date – Date original current plan started (DO NOT CHANGE)
- Expiration Date – New Expiration date from Ryan White plan.
- Save



- For clients who have fallen out of care and are returning.
- Tier – Employee only.
- Effective Date – New Liberty Dental Effective Date.
- Expiration Date – Ryan White Expire Date.
- Save

Step 4. The form must be included with the eligibility documents in CAREWare.



Conten	Attach Date	Attach User	Mod Date	Mod User	Fi	File Name	Comment
Eligibilit	9/23/2022	FTANNAHILL	9/23/2022	FTANNAHILL	.p	CookJohnE VitalRe	Confirmation of Vita
Eligibilit	1/24/2022	SJAUREGUITO	1/24/2022	SJAUREGUITO	.p	2020 FPL	Test
Eligibilit	1/15/2020	LANGELGUADRON	1/15/2020	LANGELGUADRON	.p	EIVF - Revised 201	EVIF Test Form
Eligibilit	1/14/2020	AJACINTO	1/14/2020	AJACINTO	.p	1. Brand New Packe	TEST
Eligibilit	12/18/2019	LANGELGUADRON	12/18/2019	LANGELGUADRON	.p	2019-Federal-Pover	Income Poverty leve
Eligibilit	04/11/2019	SPENN	4/11/2019	SPENN	.p	18-04 Universal Elig	
Eligibilit	08/03/2018	SPENN	8/3/2018	SPENN	.p	.NV ADAP Formular	ADAP Formulary- Te

Subrecipients that have access to CAREWare Part B are responsible for uploading forms on the client's behalf. Subrecipients that do not have access to Part B CAREWare will have a partner organization that mirrors clients and uploads documentation for them.

Part A Agency	Part B Agency
University Medical Center Wellness Clinic Community Counseling Center	Access to Healthcare Network
Nye County Health and Human Services	Aid for AIDS Nevada
Dignity Health	Southern Nevada Health District

The subrecipient will designate a lead case manager and a backup, who will be responsible for entering information into the Liberty Dental website. These managers will also be responsible for updating information for clients once they have been entered into the system.

Health Insurance Decision Tree

If NMAP will be assisting you to pay your health insurance premium, please read this information thoroughly so you know what types of health insurance NMAP will pay for

Should you enroll in employer-based health insurance or Marketplace health insurance?
Does your employer or a spouse's employer offer health insurance that:

1. Is affordable? (Costs less than 9.5% of household income), and
2. Offers access to medications and primary/specialty care?

Yes

If you are already covered, it is recommended that you should stay on your employer-based health insurance.

- NMAP may be able to pay your employer-based premiums.
- Present your monthly invoice/paystub to Access to Healthcare Network for premium payment. Failure to provide your invoice/paystub will result in the loss of premium payment assistance and you will be responsible for paying your own premiums.
- NMAP will not pay for your Marketplace premium if you opt out of employer-based health insurance.

If you are not currently covered but you become eligible at any time to enroll in an employer-based health insurance plan, you must enroll in the employer-based plan and notify Access to Healthcare Network.

- If you do not enroll in an employer-based plan, NMAP will not continue to pay for your Marketplace premium.

No

You should enroll into a Marketplace health insurance plan.

- Choose a plan that has been approved by NMAP to ensure you can be assisted with your premium. Gold tier options are the only available considerations.
- Contact Access to Healthcare Network to speak with the Insurance Specialist for assistance enrolling in a Marketplace plan.
- Present your monthly invoice to Access to Healthcare Network for premium payment. Failure to provide your invoice could result in the loss of premium payment assistance and you could be responsible for paying your own premiums.

References

Ryan White Part B Standard of Care guidance NMAP and Health Insurance to Provide Medications

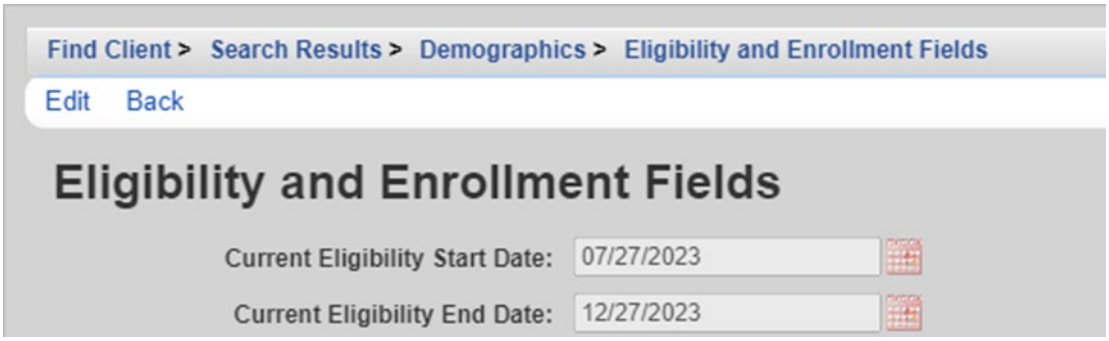
Referrals for Medication or Insurance Assistance

Instructions

The provider who administers a portion of the statewide Nevada AIDS Drug Assistance Program (ADAP), also known as the Nevada Medication Assistance Program (NMAP), Access to Healthcare Network (AHN), also has other services that they provide to the community of persons living with HIV in Nevada. All referrals to AHN for NMAP services should follow the below procedures to ensure requests are addressed in a timely manner.

Referral Process for Initiating Agency

When you are sending a referral for NMAP services to the Access to Healthcare Network domain, for a client who is requesting medication or health insurance assistance, ensure that the client is currently enrolled in the RWPB Program by looking at the Eligibility and Enrollment Fields tab.



The next set of instructions are shown in images on the following pages.

- Then navigate to the Referrals tab and click Add Referral,
- Select that Date that you are making the referral,
    - Referrals should never be backdated. The date of the referral should reflect the date that the referral is sent
- Select *Internal* in the Type section,
- Select *Access to Healthcare Network* in the Refer-To Provider section,
- Select the Requested Service Category Type as *Health Insurance Program (HIP),*
- Select the appropriate Referral Class based on the client's needs.

Referral Class Options:

- *NMAP Medication Assistance*- select for uninsured full-pay medication assistance or insured copay medication assistance;
- *NMAP Premium Assistance*- select for premium payment assistance and assistance enrolling into health insurance; and
- *Medical Copay Assistance*- select for medical/ dental/ vision copay assistance.

If the client needs immediate NMAP services, please select Emergency Referral. An emergency is defined as the client possessing less than seven (7) calendar days of medication; this includes clients who are newly diagnosed and in need of medication within seven (7) days.

Referral Process for NMAP Referral Receiving Agency

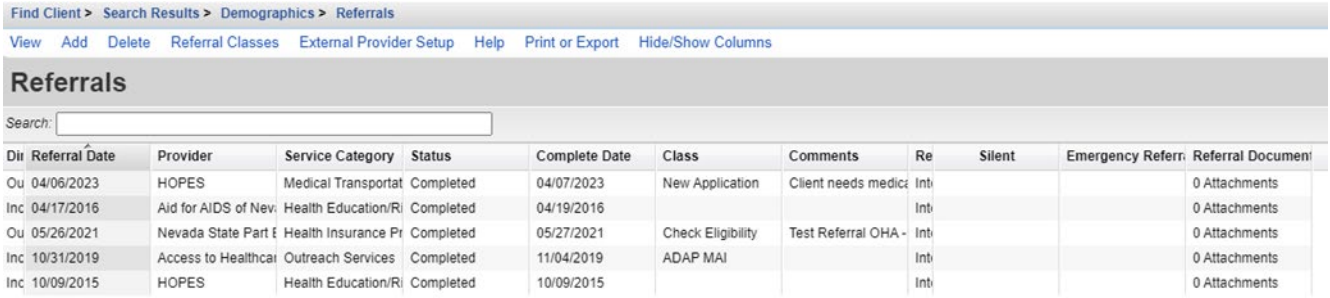
When a referral for NMAP services is received by the Access to Healthcare Network (AHN) domain, the AHN agency staff will review the requested service, referral notes, and client eligibility information. If the necessary NMAP documents are provided with the initial referral, then the client may be enrolled directly into the requested NMAP medication or health insurance program. If the client is ineligible or refuses to enroll into health insurance coverage, the client will be reassessed for NMAP uninsured medication assistance. If the client enrolls into insurance coverage, the client will be reassessed for NMAP insured medication assistance and/or health insurance premium assistance.

Do not backdate the referral. The agency staff will have 48 hours to complete or deny an NMAP emergency referral and 14 calendar days to complete or deny a non-emergency NMAP referral. Changes to the date of referral can negatively impact the ability of AHN to respond to requests in a timely manner.

To be able to process the NMAP referral, the client's Ryan White Universal Eligibility Application must be complete and uploaded into CAREWare. If for any reason the Ryan White Universal Eligibility Application is missing required eligibility documents, the NMAP referral will be rejected back to the originating referral agency with comments indicating the reason for denial. The agency staff will notify the initiating agency when a referral has been rejected.

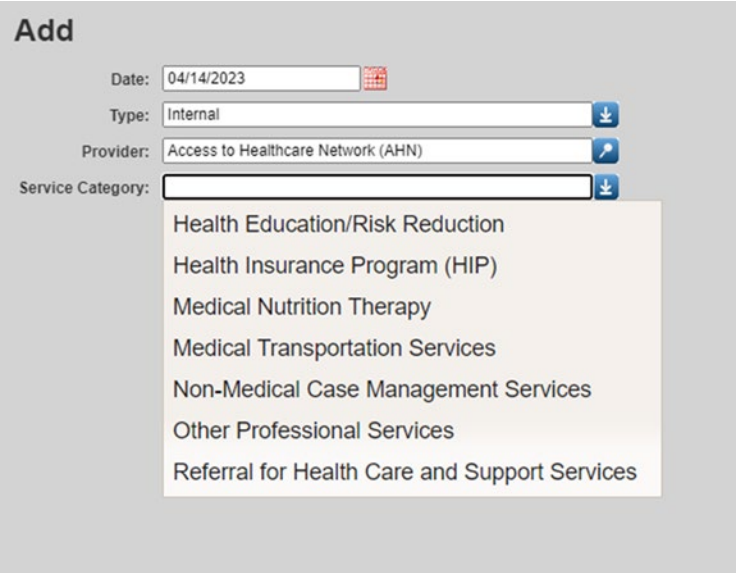
Step-by-Step Referral Process for Initiating Agency

To send an NMAP referral, navigate to the Referrals tab and click Add Referral



Dir	Referral Date	Provider	Service Category	Status	Complete Date	Class	Comments	Re	Silent	Emergency Referr	Referral Document
Ou	04/06/2023	HOPES	Medical Transportat	Completed	04/07/2023	New Application	Client needs medica	Int			0 Attachments
Inc	04/17/2016	Aid for AIDS of Nev	Health Education/Ri	Completed	04/19/2016			Int			0 Attachments
Ou	05/26/2021	Nevada State Part E	Health Insurance Pr	Completed	05/27/2021	Check Eligibility	Test Referral OHA -	Int			0 Attachments
Inc	10/31/2019	Access to Healthcar	Outreach Services	Completed	11/04/2019	ADAP MAI		Int			0 Attachments
Inc	10/09/2015	HOPES	Health Education/Ri	Completed	10/09/2015			Int			0 Attachments

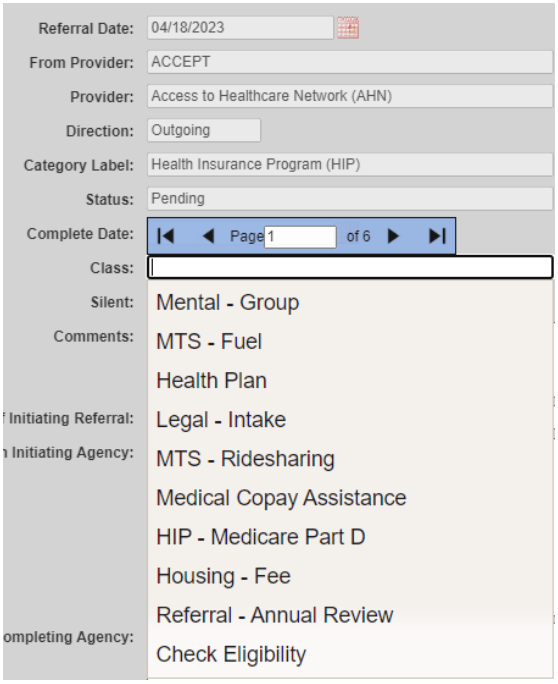
Select that Date that you are making the referral, select *Internal* in the Type section, and select *Access to Healthcare Network* in the Refer-To Provider section. Select the Requested Service Category Type as what is appropriate for the needs of the client.

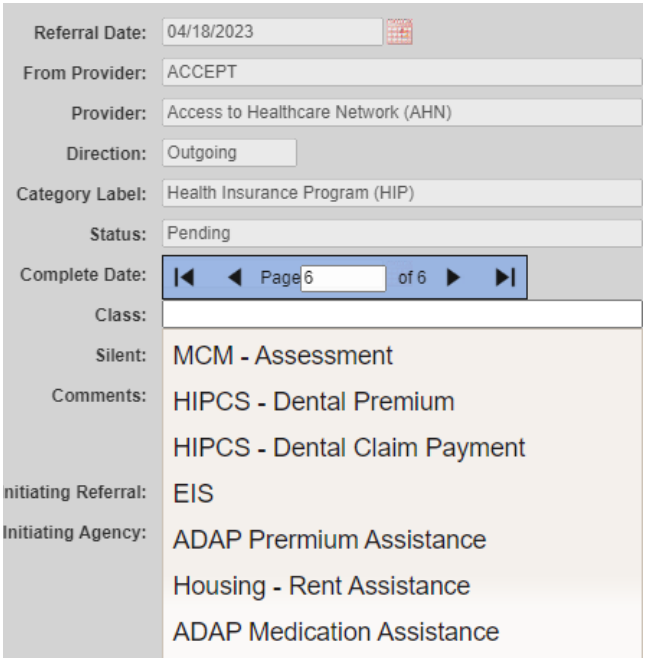


Next, you will be asked to select a Referral Class based on the client's needs based on the following guidance:

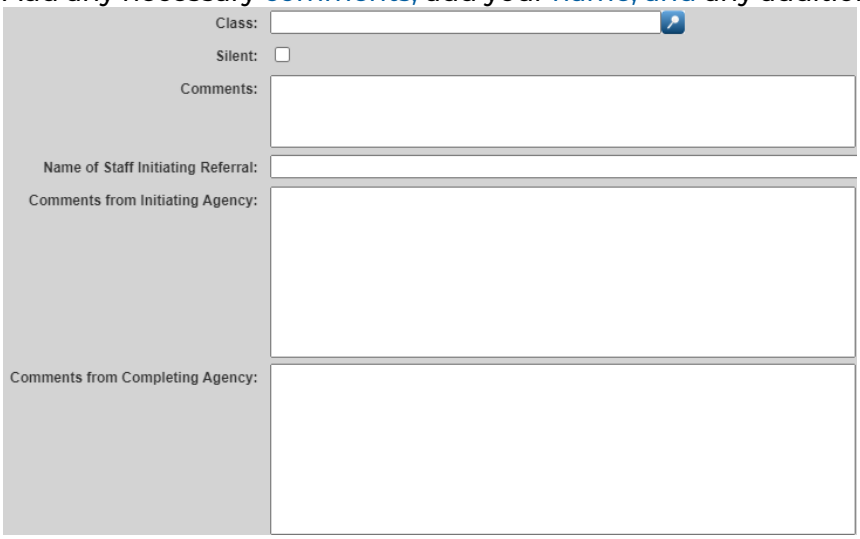
Referral Class Options:

- *ADAP Medication Assistance* – Select for uninsured full-pay medication assistance or insured copay medication assistance
- *ADAP Premium Assistance* – Select for premium payment assistance and assistance enrolling into health insurance
- *Medical Copay Assistance* – Select for medical/dental/vision copay assistance

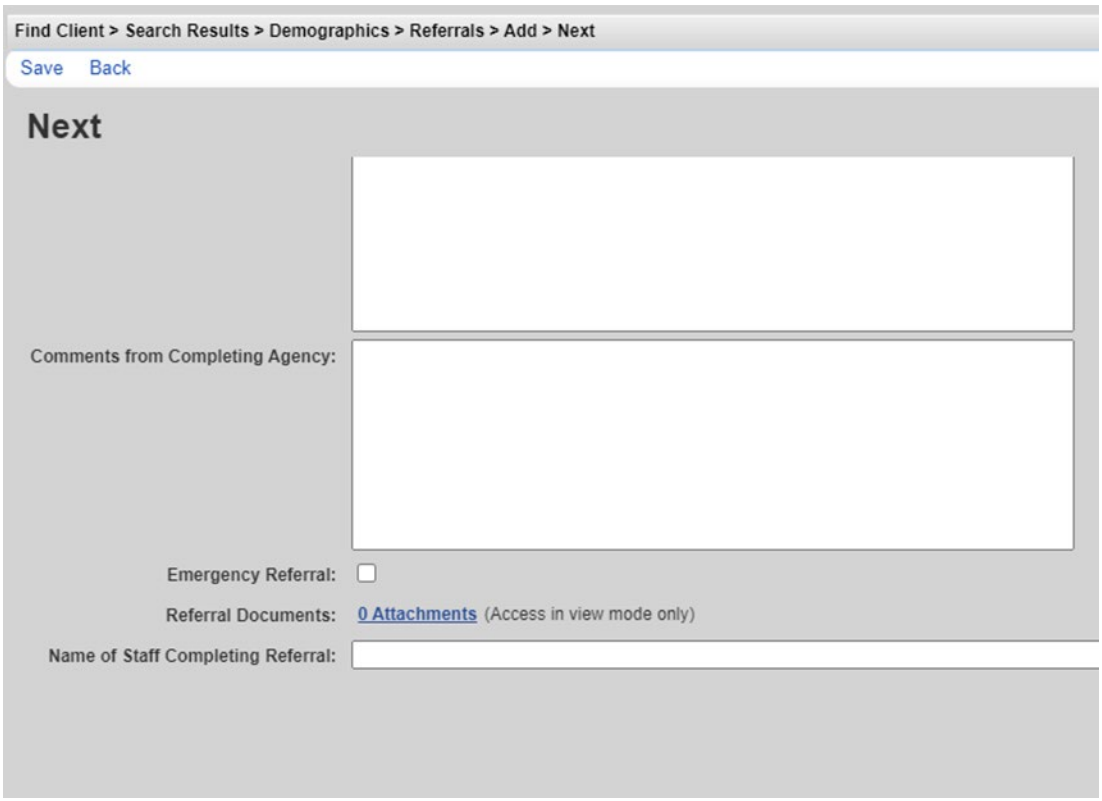




Add any necessary comments, add your name, and any additional details from your agency.



If the client needs immediate NMAP services, please select Emergency Referral. Also, make sure to include any necessary Attachments to complete the referral.


Find Client > Search Results > Demographics > Referrals > Add > Next
Save
Back
Next
Comments from Completing Agency:
Emergency Referral:
Referral Documents:
0 Attachments
(Access in view mode only)
Name of Staff Completing Referral:

Early Refill, Lost, Stolen and Vacation Override Procedure

Instructions

The process for requesting overrides, related to early refills for lost, stolen or vacation medications will have to be initiated at the pharmacy level. When a pharmacy submits a claim to MMA, and they receive a Deny code of "Early Refill" the pharmacy will need to submit a request for an override. For an override to be approved by OoH, a client must be eligible to receive NMAP services in the month(s) they are requesting services. Steps for each are listed below:

Lost/Stolen Medications:

MMA has been given the authority by OoH to allow for one (1) Lost/Stolen override once per drug; per calendar year, on all prescribed medications, excluding narcotics, on the NMAP formulary. Regardless of the medication being lost or stolen, the client will only be given one (1) override once per drug, per calendar year.

Vacation Medications:

Insured Clients

- OoH currently allows for a 90-day supply of medication only if a 90-day prescription is written by the medical prescriber.
- Insured clients will need to utilize their Health Insurance's Pharmacy Network and OoH will continue to cover the copayment if the client is eligible for services.
- If Health Insurance's Pharmacy Network does not allow for vacation medications, insured clients will need to reach out to NMAP for an exception.
- For insured clients, out-of-state on vacation seeking medication assistance, clients will need to reach out to NMAP to ensure clients are eligible to receive services before authorization will be given to Magellan to approve these claims.

Uninsured Clients

- OoH currently only allows for a 30-day supply of medication.
- Uninsured clients who are out-of-state on vacation and seeking medication assistance will need to reach out to NMAP to ensure clients are eligible to receive services before authorization will be given to Magellan to approve these claims.

Clients have the right to appeal any determination made concerning a denial for lost/stolen or vacation overrides. All appeals will need to be emailed to Sarah Cowan, NMAP Coordinator at scowan@health.nv.gov, no later than five (5) working days after notification of a denial determination. The appeal process can take up to seven (7) working days.

Administration of Cabenuva

Background

Cabenuva – co-packaged cabotegravir and rilpivirine extended-release injectable suspensions – was approved by the U.S. Food and Drug Administration on January 21, 2021. Cabenuva is indicated as a complete regimen for the treatment of HIV-1 infection in adults to replace the current antiretroviral regimen in those who are virologically suppressed on a stable antiretroviral regimen, with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine. Cabenuva is an extended-release antiretroviral gluteal intramuscular injectable that requires administration by a licensed healthcare professional in a licensed healthcare setting.

On October 1, 2022, Cabenuva was added to the NMAP formulary. Due to the unique administration process Cabenuva requires, NMAP has funded Community Outreach Medical Center (COMC), through a pilot project, to be the administration site for uninsured clients as well as NMAP clients whose' insurance do not cover Cabenuva. This pilot project is only for southern Nevada clients currently.

Instructions

Uninsured Clients:

All southern Nevada uninsured clients considered full-pay through NMAP, are required to be referred to COMC for administration of Cabenuva.

- External Referrals: The COMC external referral form is required to be completed by the referring primary care physician (PCP) to start the process of Cabenuva. Once the completed form is returned to COMC, COMC will follow their Standard Operating Procedure (SOP) Cabenuva Program-External Referral, to allow the client access to Cabenuva.
- Internal Referrals: If the client is already a patient at COMC, the SOP Cabenuva Program-Internal Referral process should be followed to allow the client access to Cabenuva.

Insured Clients:

All southern Nevada insured clients whose insurance does not cover Cabenuva are required to be referred to COMC for administration of Cabenuva.

- External Referrals: The COMC external referral form will need to be completed by the referring PCP to start the process of Cabenuva. Once the completed form is returned to COMC, COMC will follow their Standard Operating Procedure (SOP) Cabenuva Program-External Referral, to allow the client access to Cabenuva.
- Internal Referrals: If the client is already a patient at COMC, the SOP Cabenuva Program-Internal Referral process should be followed to allow client access to Cabenuva.

Note: For Northern Nevada Clients, only Northern Nevada HOPES established patients can seek assistance for access to Cabenuva at this time. As of now, only patients who are on either Nevada Medicaid, Medicare with Part D plan or on a private commercial insurance are being offered Cabenuva through Northern Nevada HOPES.

Administration of SUNLENCA

Background

Sunlenca (lenacapavir)- was approved by the U.S. Food and Drug Administration (FDA) on December 22, 2022, for people living with HIV/AIDS (PLWHA) whose HIV infections cannot be successfully treated with other available antiretrovirals due to resistance, intolerance, or safety considerations.

On November 20,2023, Sunlenca was added to the NMAP formulary. Due to the unique administration process Sunlenca requires, NMAP has funded Community Outreach Medical Center (COMC),to be the administration site for uninsured clients as well as NMAP clients whose' insurance does not cover Sunlenca. This only for southern Nevada clients currently.

Instructions

Uninsured Clients:

All southern Nevada uninsured clients considered full-pay through NMAP, are required to be referred to COMC for administration of Sunlenca.

- External Referrals: The COMC external referral form is required to be completed by the referring primary care physician (PCP) to start the process of Sunlenca. Once the completed form is returned to COMC, COMC will follow their Standard Operating Procedure (SOP) Sunlenca Program-External Referral, to allow the client access to Sunlenca.
- Internal Referrals: If the client is already a patient at COMC, the SOP Sunlenca Program-Internal Referral process should be followed to allow the client access to Sunlenca.

Insured Clients:

All southern Nevada insured clients whose insurance does not cover Sunlenca are required to be referred to COMC for administration of Sunlenca.

- External Referrals: The COMC external referral form will need to be completed by the referring PCP to start the process of Sunlenca. Once the completed form is returned to COMC, COMC will follow their Standard Operating Procedure (SOP) Sunlenca Program-External Referral, to allow the client access to Sunlenca.
- Internal Referrals: If the client is already a patient at COMC, the SOP Sunlenca Program-Internal Referral process should be followed to allow client access to Sunlenca.

Community Outreach MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

REFERRAL FOR COMC SERVICES

P: (702) 657-3873 - F: (702) 636.0787
Secure Email: referral@nvcomc.org
1090 E. Desert Inn Road – Las Vegas, NV 89109

Date: _____

Submit completed referral form through CAREWare A or B or via Secure Email

REASON FOR REFERRAL (Please check all that apply)

PHYSICAL HEALTH SERVICES:	ADDITIONAL SERVICES:
☐ Primary Care/ General Medicine ☐ PrEP & PEP ☐ CABENUVA ☐ SUNLENCA	☐ Ryan White Services ☐ Community Resources ☐ Other _____

Referring Agency: _____ Referred by: _____

Phone number: (___) _____ Email: _____

Referring Provider: _____ Provider Signature: _____

CLIENT INFORMATION

Client Name: _____ Preferred Name: _____

DOB (mm/dd/yyyy): _____ Age: _____ SSN# _____-_____-_____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ May we leave a message ☐ Yes ☐ No

Permission to call: ☐ Yes ☐ No Best Time to call: _____

Email: _____ Okay to Email? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Sex at Birth: ☐ Male ☐ Female Gender Identity: ☐ Male☐ Female ☐ MTF ☐ FTM ☐ Other: _____

Race: ☐ Black/African American ☐ White/Caucasian ☐ American Indian/ Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Other_____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown

Health insurance

Insurance Information: _____

Member ID#: _____ Group #: _____

Primary Care Physician: _____

HIV Specialist Provider: _____

ADDITIONAL NOTES/INSTRUCTIONS: **Attach supporting documents such as Labs to include Viral Load and CD4 Count; Last Progress Notes: include history of medication adherence and resistance, Proof of Diagnosis, Known Allergies, etc.**

Further Reading
NMAP Acknowledgement Form APTC Link
NMAP Acknowledgement Form Non-APTC Link
Universal Eligibility Manual 2021
Universal Eligibility PowerPoint 2022