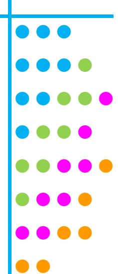
Effective Strategies for Assessing, Collecting, and Monitoring Client Charges

HRSA HIV/AIDS Bureau All Grantee Meeting
Session 217, November 27, 2012



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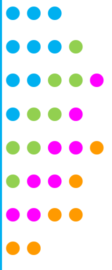
Presentation Agenda

- Overview of HIV/AIDS Bureau (HAB) requirements for Ryan White (RW) HIV/AIDS Program grantees and providers regarding verification of clients' financial status, implementation of sliding fee scale, and ensuring a cap on client charges for HIV-related services
- We address requirements for Part A, B, C, and D grantees and their funded subgrantees (i.e., providers)
- Provide practical strategies for implementing and assessing the quality of grantee and provider client charge activities
- We illustrate opportunities and challenges associated with implementing these policies by focusing on the Harris County Texas (TX) Part A program
- We will conclude the workshop by opening the session for your questions and comments

Part A and Part B Fiscal and Universal Monitoring Standards



HIV/AIDS Bureau, Division of Service Systems
Monitoring Standards for Ryan White Part A Grantees:
Part A Fiscal Monitoring Standards

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HAB Client Charge Monitoring Standards

- **Parts A and B grantee and provider policies and procedures must specify charges to clients for services**
  - Which may include a documented decision to impose only a nominal charge
- **No charges shall be imposed on clients with incomes at or below 100% of the Federal Poverty Level (FPL)**
- **Charges to clients with incomes greater than 100% of the FPL are to be based on a discounted fee schedule and sliding fee scale**
  - Provider sliding fee discount policies and schedules should ensure such clients are not charged for services
  - Clients' files and documented charge and payment data should demonstrate that the policies are correctly and consistently enforced and clients below 100% of the FPL are not charged for services
- **Caps on total annual charges for HIV services (including ADAP) are to be based on a percentage of the client's *annual* income**

Clients With Incomes Greater Than 100% of FPL

- No upper income ceiling is set for RW clients
  - Grantees may set income ceilings, however, to ensure sufficient funds are available for services
- Caps on total annual charges for HIV services must be based on a percentage of clients' *annual gross income*

Individual Income	Maximum Charge
At or below 100% of FPL	$0
100% to 200% of FPL	No more than 5% of gross annual income
200% to 300% of FPL	No more than 7% of gross annual income
Over 300% of FPL	No more than 10% of gross annual income

- "Cumulative charges" include charges for HIV-related services, including providers other than the grantee or its providers
  - Charges include enrollment fees, premiums, deductibles, cost sharing, co-payments, or similar charges
  - Applies to all services for which the provider imposes a charge
  - If the provider charges health insurers for a service, the provider must impose the same charge and provide a discount to uninsured clients using the service

Grantees Responsibilities

- Review providers'
  - Sliding fee scale policy and fee schedule
  - Eligibility criteria and slide fee eligibility application form
  - Health information system (HIS) to record client charges, payments, and adjustments
- Ensure that these policies and procedures are consistent with policies and federal requirements
- Review documentation of provider fee schedule and HIS to show that charges have been incurred
- Review providers' policies and procedures to ensure that clients with incomes < 100% of the FPL are not charged for services
- Review client files and documentation of actual charges and payments to ensure that the policy is correctly and consistently enforced and clients < 100% of the FPL are not charged for services

Provider Policies and Procedures

- **Providers must establish and implement**
  - A system for verifying clients' annual income
  - Sliding fee discount policy
  - Fee schedule, based on the current FPL set by HHS
  - Eligibility criteria and a sliding fee eligibility application form, which must be completed for each client and filed in his or her chart
  - A data system to record client charges, payments, and adjustments and have a written description of the system
    - The system should account for HIV-related charges outside the funded program (e.g., HIV clinic) including hospital or pharmacy charges

Provider Policies Must Cap and Track Charges

- **Providers must have a fee discount policy documenting**
  - Clear responsibility for annually evaluating clients to establish individual fees and caps
  - Policies, fees, and implementation, including evidence that the provider's staff understand the policies and procedures
  - How charges or medical expenses including enrollment fees, deductibles, and co-payments will be tracked
  - A process for alerting the billing system that the client has reached the cap and should not be charged for the remainder of the year
- **Change clients' billing status to "no charge" when their cap on charges is reached**
- **HAB suggests several ways providers can track charges**
  - Maintain a running total of what the provider's billing office or front desk have charged each client for HIV services
  - Develop spreadsheets or other databases to maintain this information
  - Modify existing or develop new data systems that show verified income, automatically compute sliding scale fees and/or discounts, and automatically track progress toward meeting the client's cap

Providers Must Report Fees As Grant Income

- Fees gathered from clients as part of the sliding fee process must be reported to HAB as grant income
- If a provider receives funds from Parts A, B, C, and/or D, the provider collects the fee based on the services rendered at the time of the visit, regardless of funding source
  - For reporting purposes, total program income (collected fees) can be apportioned directly or indirectly by formula

Client Responsibilities

- Provide accurate income information to assess their FPL and fees
- Client's are responsible for providing receipts demonstrating payments to RW-funded providers, other departments in the same agency, or other providers for HIV-related services

Service Categories for Which Fees Should be Charged

- The Fiscal Monitoring Standard Frequently Asked Questions (FAQs) state that the legislative requirement applies to all services for which the provider imposes charges
- If charges are imposed for a service for any clients, then that service should be included in the program's fee schedule
  - Example: A provider charges Medicaid for case management. Thus, the provider must charge uninsured clients using case management a discounted fee based on their FPL

Common Approaches to Billing of Services

Commonly billed

- HIV testing
- Outpatient/ambulatory medical care
- Medication and lab services
- Oral health services
- Substance abuse treatment (residential and non-residential)
- Mental health treatment
- Medical nutrition therapy
- Home health care, hospice services, and home and community-based health services
- Rehabilitation services

Service categories as defined by the HAB Program Monitoring Standards

Not or infrequently* billed

- Medical and non-medical case management*
- Health insurance, co-payment, and deductible *assistance*
- Outreach, linkage to care, peer navigation services
- Medical transportation*
- Child and respite care services
- Emergency financial assistance
- Food bank/home delivered meals
- Housing services
- Legal services*
- Psychosocial support
- Linguistic services
- Referral for health care/supportive services
- Treatment adherence counseling

Ensuring Access to Care

- HAB's Universal Monitoring Standards for Part A and Part B requires provision of services regardless of an individual's ability to pay for the services
- Providers must have sliding fee, co-payment, billing, and collection policies that do not act as a barrier to providing services, regardless of a client's ability to pay
- Providers must maintain a file of individuals refused services, with the reasons for refusal specified, including any client complaints, with documentation of complaint review and the decision reached
- Collection of client fees may not create a barrier to access to key services

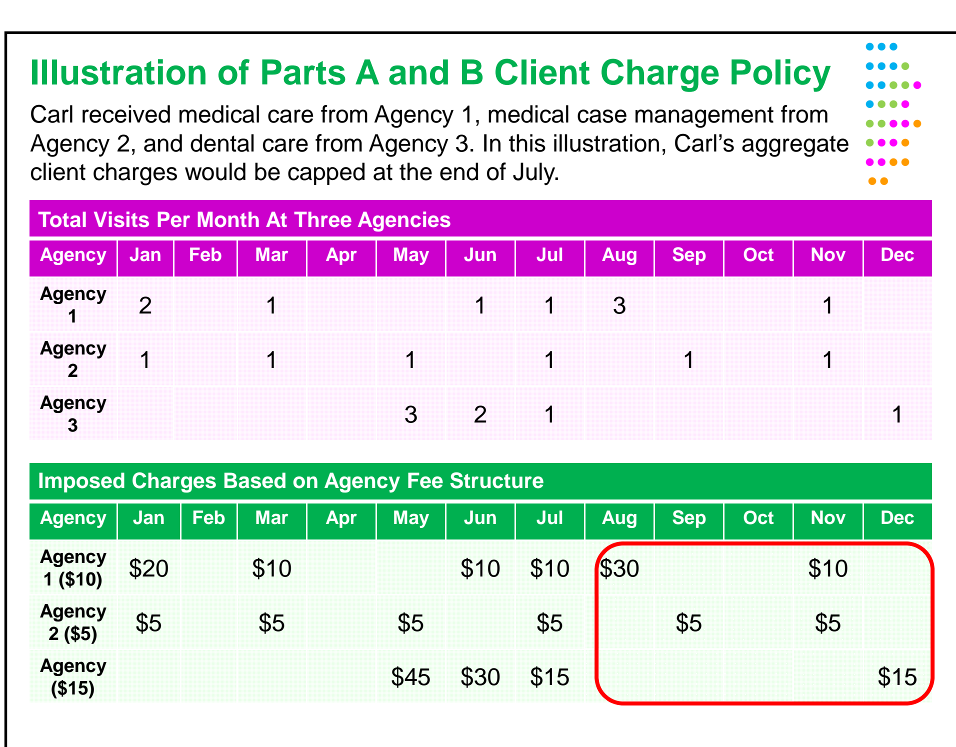


Illustration of Parts A and B Client Charge Policy

Carl received medical care from Agency 1, medical case management from Agency 2, and dental care from Agency 3. In this illustration, Carl's aggregate client charges would be capped at the end of July.

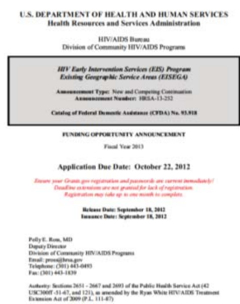
Total Visits Per Month At Three Agencies

Agency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Agency 1	2		1			1	1	3			1	
Agency 2	1		1		1		1		1		1	
Agency 3					3	2	1					1

Imposed Charges Based on Agency Fee Structure

Agency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Agency 1 ($10)	$20		$10			$10	$10	$30			$10	
Agency 2 ($5)	$5		$5		$5		$5		$5		$5	
Agency ($15)					$45	$30	$15					$15

Part C Funding Opportunity Announcement (FOA)



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

HIV/AIDS Bureau
Division of Community HIV/AIDS Programs

HIV Early Intervention Services (EIS) Program
Existing Geographic Service Areas (EISEGA)

Announcement Type: New and Competing Continuation
Announcement Number: HRSA-13-252

Catalog of Federal Domestic Assistance (CFDA) No. 93.918

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2013

Application Due Date: October 22, 2012

Ensure your Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration may take up to one month to complete.

Release Date: September 18, 2012
Issuance Date: September 18, 2012

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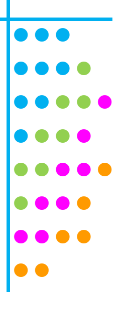
Authority: Sections 2651 - 2667 and 2693 of the Public Health Service Act (42 USC300ff -51-67, and 121), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87)



Part C Early Intervention Services (EIS) Program

- The Part C EIS FY 2013 FOA summarizes the program's client charge policy
- Grantees must develop consistent and equitable policies and procedures to verify patients' financial status, implement of a sliding fee scale, and ensure a cap on patient charges for HIV-related services
- Grantees must provide a system to discount patient payment for charges by developing and using a sliding discounted fee schedule that is published and made readily available
- Patients at or below 100% of the FPL should not be charged, while patients above the FPL should be charged for services
- Annual cumulative charges to an individual patient for HIV-related services is limited to:

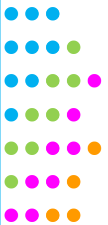
Individual Income	Maximum Charge
At or below 100% of FPL	$0
101% to 200% of FPL	No more than 5% of gross annual income
201% to 300% of FPL	No more than 7% of gross annual income
Over 300% of FPL	No more than 10% of gross annual income

Part C Early Intervention Services (EIS) Program

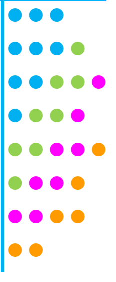
- Each grantee is responsible for creating its own sliding fee scale in accordance with the most recent FPL guidelines
- The fee schedule *may* be based on the patient's income or household size and income
- Grantee must track the patient's income and charges imposed
- To comply with this requirement, grantees may need to train staff, develop patient education materials, and/or place notices in waiting rooms and reception areas

Providers Funded by Parts A, B, C, and/or D

- Multiply-funded providers are common in RW, and clients may receive services supported by a combination of these "Parts"
- The provider should collect fees based on the services rendered at the time of the visit, regardless of the funding source
- Total program income resulting from program income (i.e., collected fees) can for the purposes of reporting be apportioned directly or indirectly by formula



HRSA Bureau of Primary Health Care (BPHC) Client Charge Policy



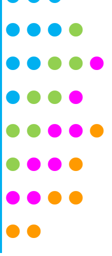
Federally Qualified Health Centers (FQHCs)

- Some RW-funded providers are also funded by BPHC
- Providers funded by BPHC must be aware of and adhere to their patient charge statutory requirements
  - Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f)
- FQHCs must has a system in place to determine eligibility for patient discounts adjusted on the basis of patients' ability to pay
  - Provide a full discount to individuals and families with annual incomes at or below 100% of the FPL guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of FPL, fees must be charged in accordance with a sliding discount policy based on family size and income
  - No discounts may be provided to patients with incomes over 200% of the FPL
- More information from BRPHC can be found at: http://www.bphc.hrsa.gov/about/requirements/index.html#MANAGEMENTANDFINANCE

BPHC FQHC Sliding Fee Discounts

- Individuals at or below 100% FPL must receive a full discount on fees for services, however a nominal fee may be charged
- The fee schedule must slide/provide varying discount levels on charges to individuals between 101% and 200% of the FPL
- There must be no discount for patients above 200% FPL
- The fee schedule must be based on the most recent FPL guidelines, and must be updated annually
- Patients must be notified of the availability of the sliding fee discounts

Practical Strategies for Assessing Income and Applying the Sliding Fee Scale



Role of Grantees

- Establish or update sliding fee scale and charge policies to ensure consistency with HAB requirements
  - Strive for administrative simplicity
- Inform key stakeholders about the policy
  - Including Planning Council, other planning bodies, consumers, and providers
- Train providers to implement grantee policies and provide TA
- Develop linguistically appropriate standardized client materials explaining the policy for use at intake and recertification
- Design or refine a HIS to track client charges, set payment caps, and alert providers that clients' caps are met
- Monitor implementation of HAB and grantee policies by providers, and refine the policies as needed
- Account for accrued client payments among all funded providers
  - Ensure that payments are returned to HIV programs

Role of Providers

- Strive for administrative simplicity in designing and implementing client charge policies and procedures
- Be aware of broader agency client charge policies that may conflict with those of the RW grantee
  - Seek guidance from your grantee to remediate those conflicts to the extent possible
- Set charges for services provided to HIV+ clients if a charge structure is not already in place
- Design or refine a billing system to track client charges, account for payments, and report payments to the grantee
- Assess and document client income every six months
  - Recompute clients' fees annually
- Coordinate with your grantee to activate annual client caps when they are met
- Train staff to assess charges, gather and account for client payments, and report client charges to the grantee
- Apply continuous quality improvement techniques (CQI), implement and refine the policies and procedures

Setting Client Fee Schedules

- **Several options may be used to apply charges**
  - Existing charge structure based on charges set by the grantee for each type of service unit
  - Existing agency or program charge structures used to bill health insurers
  - Flat charge per visit or service, similar to co-payments set by health insurers
  - Set charges based on "unit cost" methods
- **In setting fees, it is important to strive for administrative simplicity that is easily understood by clients and staff and tracked in your accounting system**
  - To the extent possible, charge procedures should be consistent with existing procedures to reduce confusion

Assessing and Computing Income

- Income assessment should be conducted at intake and recertification every six months, per HAB monitoring standards
  - Staff should be trained at least annually
- Calculation of the sliding fee is based on the *client's* income
  - *This differs from the calculation of household income, commonly used by grantees to determine eligibility for Part A and Part B services*
- It is important to obtain written documentation of income and to carefully review those documents
  - Avoid documents self-generated by clients, such as IRS tax forms or other information substantiating earned income
- Obtain documentation for federal disability or retirement income, to account for annual cost of living adjustments (COLAs) awarded on January 1st
- Gross monthly income should be annualized (i.e., monthly income X 12 months) to calculate annual income

Income Sources to be Identified At Intake & Reassessment

- Earned salary or wages through full, part-time, or self-employment
- Social Security Old Age and Survivor Benefits
- SSI or SSDI
- TANF, General Assistance (GA), or publicly funded income maintenance programs
- Child or spousal (alimony) support
- Retirement or pension benefits (veterans, military active duty, and commercial plans)
- Commercial short or long-term disability benefits
- Rental income
- Interest, dividends, annuities, royalties, trusts
- Unemployment Benefits
- Worker's Compensation
- In-kind support through free rent, utilities, food, and other basic necessities

Self-Employed Applicant Documentation Worksheet

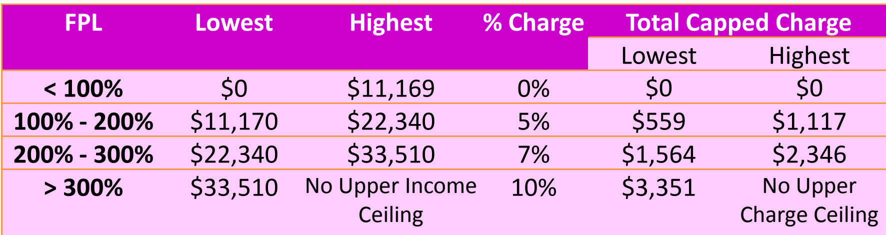
Tax Forms Required	Type of Self-Employment: Sole Proprietor	Farm (Sole Proprietor)	Rental Real Estate	Partnership	Farm Partnership	S-Corporation (Including Farm S-Corporations)	Farm Rental
1040 US individual income tax return	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Schedule C (Form 1040) profit or loss from business	Yes						
Schedule E (Form 1040), supplemental income and loss			Yes	Yes	Yes	Yes	Yes
Schedule F (Form 1040), profit or loss from business		Yes			Yes		
Schedule K-1 (Form 1065), partner's share of income, deductions, credits, etc				Yes	Yes	Yes	
Form 1064, US return of partnership income							
Form 4562, depreciation and amortization (if filed)	Yes	Yes	Yes				Yes
Form 4835, farm rental income and expenses							Yes
Form 8825, rental real estate income and expenses of a partnership or S-Corporation (if filed)			Yes				
Form 8829, expenses for business use of your home (if filed)	Yes						
Form 1120S (US income tax return for an S-Corporation)						Yes	

To order their filed Federal Tax Return, applicants should call the IRS at 1-800-829-1040.

Assessing Clients With $0 Income

- How does the client support him/herself without income?
  - How does the client pay for food, clothing, and shelter?
- Is the client unemployed and receiving Unemployment Compensation benefits?
- Is the client unable to work due to disability? Does the client receive disability benefits?
- Does the client reside with minor children? Is the client pregnant?
  - Does the client receive TANF cash benefits?
- Does the client receive General Relief or other income maintenance program?
- Does the client receive Supplemental Nutrition Assistance Program (SNAP) benefits?
  - SNAP benefits are NOT income

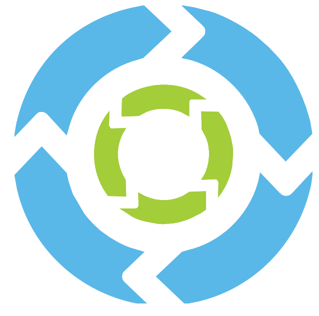
Case Example

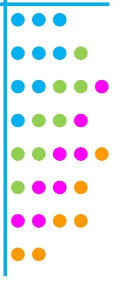


FPL	Lowest	Highest	% Charge	Total Capped Charge	
				Lowest	Highest
< 100%	$0	$11,169	0%	$0	$0
100% - 200%	$11,170	$22,340	5%	$559	$1,117
200% - 300%	$22,340	$33,510	7%	$1,564	$2,346
> 300%	$33,510	No Upper Income Ceiling	10%	$3,351	No Upper Charge Ceiling

- Joaquin earns $2,000 in monthly gross income.
- What is Joaquin's annual gross income?
- What percentage of the sliding fee scale should be applied to Joaquin's income?
- What is the capped total charge that should be applied to Joaquin's annual gross income?
- Joaquin only receives OAMC visits at your clinic. Your OAMC visit charge is $100 per visit. During how many visits should Joaquin be charged this year?

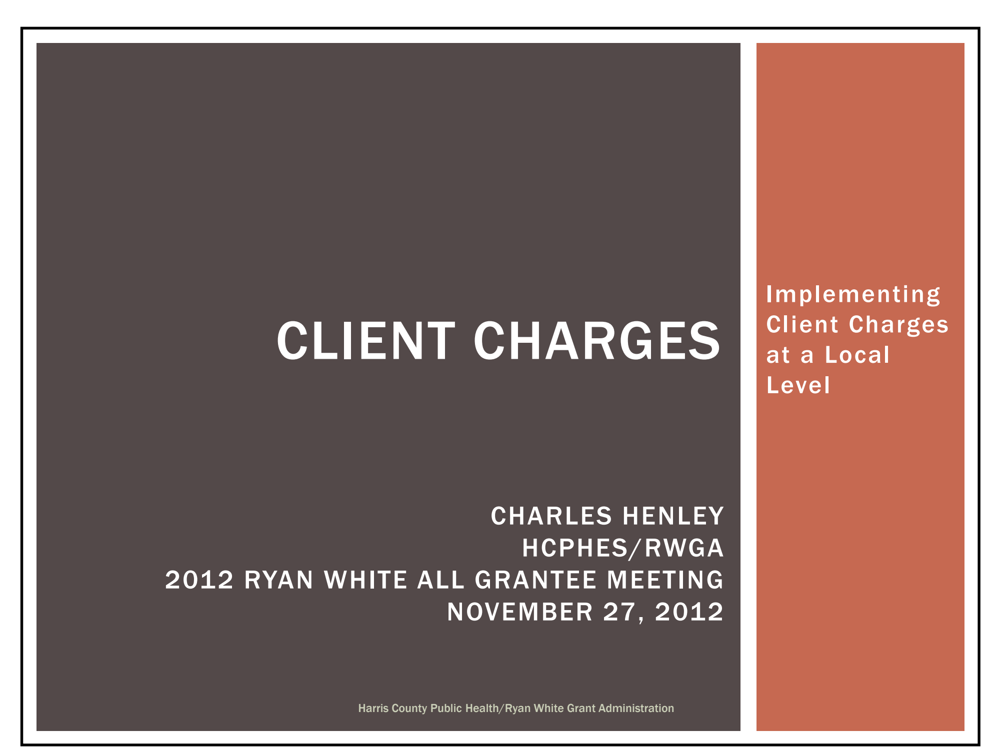
Performance Measurement and Monitoring of Client Charge Activities





ED Quality Assessment and Improvement: Design Used to Assess ED for Five Part A Grantees

Key Facts	Grantee 1	Grantee 2	Grantee 3	Grantee 4	Grantee 5
Region	Southwest	Northeast	South	South	South
Service Area	Large urban, and adjoining rural areas	Suburban, and adjoining rural counties	Moderate urban, rural counties	Large urban	Large urban, and adjoining rural areas
Providers	1 hospital-based HIV clinic, 2 FQHCs, 1 CHC	2 ASOs, 2 hospital-based HIV clinic2, 1 FQHC, 1 county health dept	3 ASOs (1 co-located in HIV clinic), 1 county health dept	Centralized Part A ED Unit	3 ASOs, 2 community ID practices, 1 county health dept
Assessment Design	Chart review	Chart review	Chart review	Electronic records	Chart review
# Charts Reviewed	285	407	325	144	493
Error Rates-Household Income	Not Assessed	**74%**	**77%**	**35%**	Not Assessed



BEFORE NATIONAL MONITORING STANDARDS

- Prior to 2008 most Houston EMA HIV/AIDS providers did not implement client charges
- The economic slowdown beginning in 2008 led to less federal, state and local revenue available to agencies
- By 2010 most Houston EMA providers of clinical services (OAMC, medications, dental, mental health and substance abuse treatment, etc.) had implemented sliding fees
- RFPs and contracts already included sliding fee rules
- Grantee found many providers did not implement sliding fees in accordance with RW guidelines
- Consumers and agency staff were often confused about sliding fee charges – often became an adversarial issue

Harris County Public Health/Ryan White Grant Administration

FY 2010/11 IMPLEMENTATION

- Ensured RFP, contract language and standards of care were aligned with sliding fee rules under the National Monitoring Standards
- Moved to semi-annual eligibility recertification (2011)
- Ensured agencies implemented effective systems to determine RW eligibility, and track fees charged and collected
- Ensured agencies implemented culturally and linguistically appropriate eligibility and fee collection processes
- Supported training of agency eligibility workers, patient navigators, and case managers in RW sliding fee policies and procedures
- Along with Planning Council, conducted numerous Town Hall meetings with consumers and agency personnel

Harris County Public Health/Ryan White Grant Administration

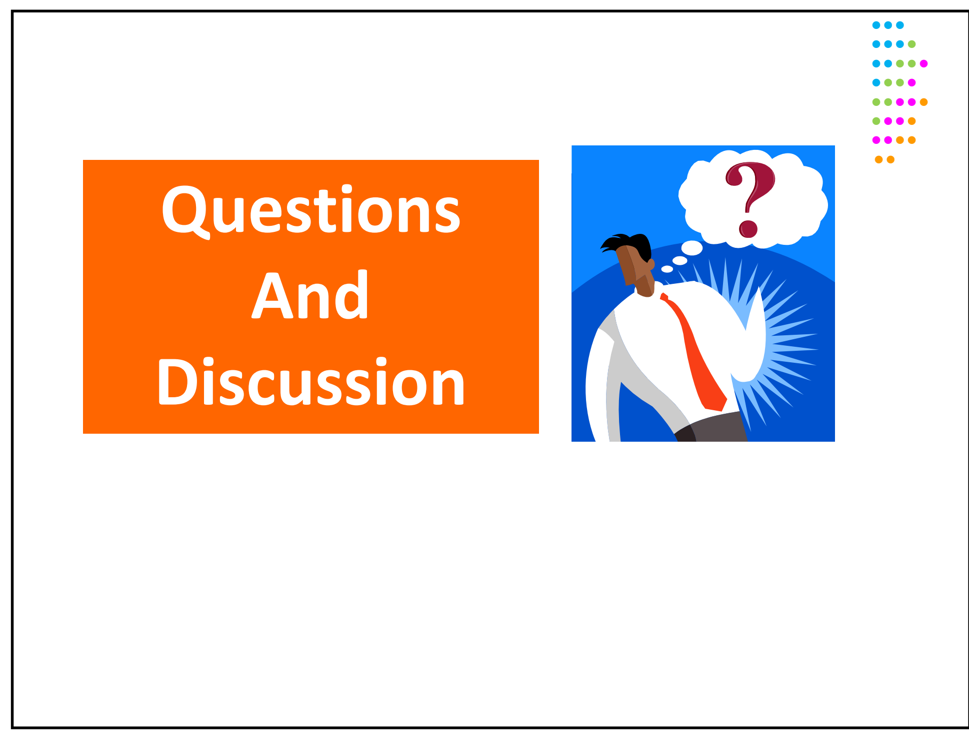
FY 2011/12 IMPLEMENTATION

- Incorporated required training for agency personnel on RW fee requirements into standards of care
- Incorporated review of agency sliding fee processes into annual programmatic and fiscal monitoring activities
- Agencies must have system to both track fees collected and to document eligible fees paid to other providers
  - Impractical to maintain fees collected information in an EMA-wide database
  - Agencies must implement sliding fee assessment and payment tracking in a consistent manner (e.g., in Houston, agencies must use the calendar year for documenting payments against annual cap)
- Fees collected must be included in annual end of year report of program income

LESSONS LEARNED

- Agency personnel responsible for fee collection are often not provided with adequate training and support
  - "Orders from above" to collect fees often override common sense considerations – unnecessarily pits staff against patients
  - Differing eligibility and sliding fee requirements for services funded by multiple grantees can cause confusion to both staff and consumers
- Tracking fees paid is a **shared responsibility** between agencies and consumers
  - Agencies must have efficient system to track fees charged, fees collected, and what eligible fees consumers may have paid elsewhere
  - Consumer responsible for maintaining receipts for eligible fees paid and providing copies to providers when accessing RW funded services
- Share success stories and best practices among agencies

Harris County Public Health/Ryan White Grant Administration


Questions
And
Discussion
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