Ryan White All Grantee Meeting

Enrollment & Eligibility: How to Manage the Patient Sliding Fee Scale and Cap on Charges

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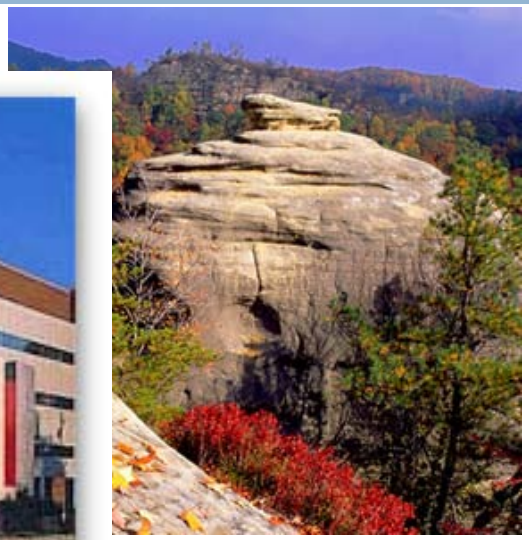
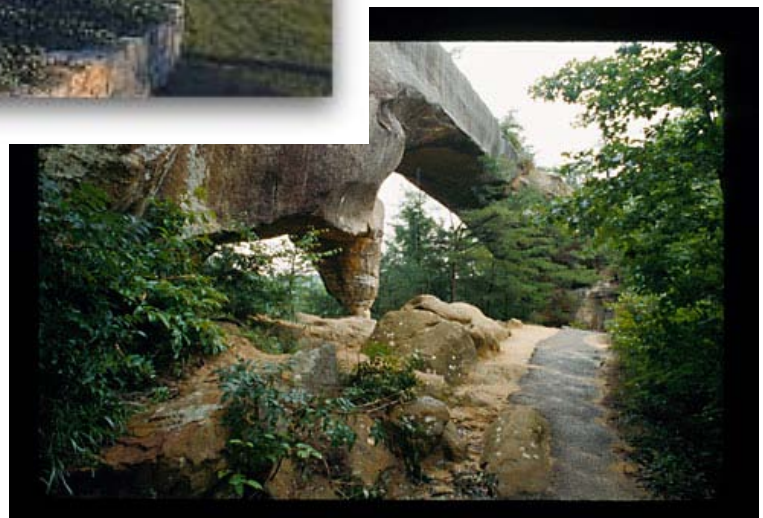
The Bluegrass Care Clinic





ICE BREAKER

Presentation Outline

- Ryan White Program Expectations
  - Services
  - Reporting
  - Enrollment
  - Eligibility
  - Sliding Fee Scale
  - Cap on Out of Pocket Charges

Presentation Outline

- Collecting Client Level Financial Data
  - Enrollment Processes
  - Data Collection Reporting
- Using Eligibility & Enrollment to Manage Multiple Funding Streams

Ryan White Program Expectations

Ryan White Services

- Ryan White Services are Specifically Designed to:
  - Assist patients that do not have sufficient health care coverage of financial resources for coping with HIV disease
  - fills gaps in care that are not covered by any other sources (public or private)
  - Serve as the Payer of Last Resort for uninsured or underinsured

Ryan White Program Expectations Patient Payment for Services

- Programs must have consistent and equitable policies/procedures related to
  - verification of patients' financial status
  - implementation of a sliding fee scale
  - And determining a cap on patient charges for HIV-related services.

Ryan White Services

- Ryan White Programs are to Provide Services Regardless of an individual's Ability to Pay for Services.
- Billing, collection, co-pay, and sliding fee policies should not act as a barrier to providing services regardless of the client's ability to pay
- Therefore, Billing & Collection Policies should not:
  - Deny services for Non-Payment
  - Deny Assistance for inability to produce income
  - Require Full Payment Prior to Service

Ryan White Eligibility

- Program Eligibility is specified by the Individual Program, EMA, TGA, or State
- Eligibility should be determined based on:
  - HIV Diagnosis
  - Patient's Income – Federal Poverty Level
  - Insurance Status
  - Eligibility for Third Party Payer Sources
- Patients should not be denied services due to eligibility for services from the Department of Veterans Affairs

Ryan White
Considering Patient Eligibility

- Are there Program Restrictions by:
  - Service Area (Some Counties covered, others are not)
  - Federal Poverty Level (Patients excluded that are above 300% of the poverty level)
  - Sex/Age (Part D)

Ryan White Enrollment

- Patients should be enrolled annually and reassessed every six months for income or eligibility changes
- Enrollment should include an assessment of:
  - HIV/AIDs Diagnosis
  - Income (Federal Poverty Level Assessment)
  - Insurance Status
  - Determination of Eligibility for other Third Party Payer Sources

Ryan White Sliding Fee Scale

- Each programs is responsible for developing a system to discount patient payment for charges (Sliding Fee Scale)
- The scale must be based on the patient's income and the federal poverty level published annually by the Department of Health and Human Services (DHHS).
- The Ryan White Legislation
  - Prohibits imposing a first-party charge on individuals whose income is at or below 100 percent of the Federal Poverty Level
  - Requires that individuals with incomes above the official poverty level be charged for services.

Current Federal Poverty Level

DHHS 2012 Poverty Level
http://aspe.hhs.gov/poverty/12poverty.shtml

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890
For families/households with more than 8 persons, add $3,960 for each additional person.	

* Web-site has more specific information for Hawaii & Alaska

Determining Patients Poverty Level

- Poverty level is expressed as a percentage of the poverty level.
- Part B/ADAP considers the entire household income when determining eligibility.
- When determining eligibility on sliding fee scale and cap on charges our program was instructed by our project officer to use the income of the HIV-positive person and any dependents.

Determining Patients Poverty Level

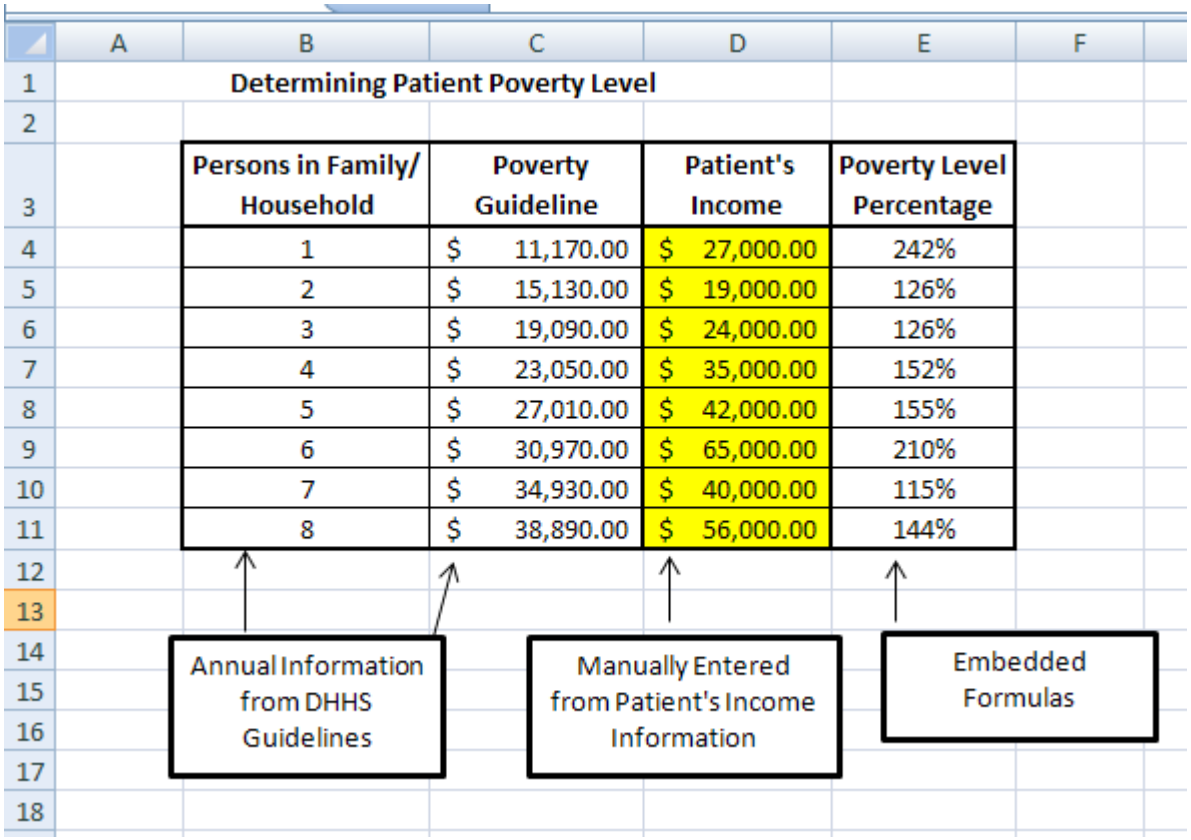
- Example 1– The 2012 poverty guidelines state that a person making $11,170, living in a one person household is 100% of the poverty level.
  - A single person household with an income of $27,000 would be 241% of the federal poverty level ($27,000 ÷ $11,170).

Determining Household Poverty Level

- The percentage per household is determined by taking the patients household and dividing by the appropriate threshold.
- Example 2 – The 2012 poverty guidelines state that an income of $19,090 for a household of three persons is 100% of the poverty level.
  - A three person household with the same income of $27,000 would be 141% of the federal poverty level ($27,000 ÷ $19,090).

Determining Patients Poverty Level

- Formula driven worksheet can be used to determine patients poverty level

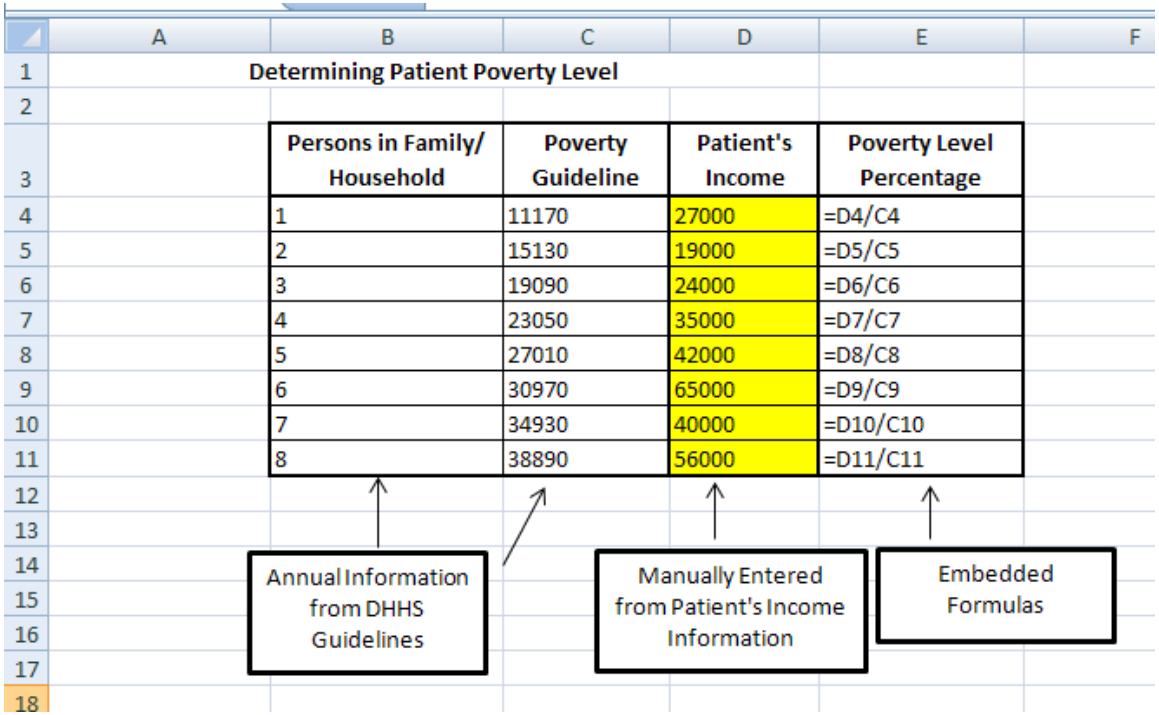


Determining Patient Poverty Level

Persons in Family/ Household	Poverty Guideline	Patient's Income	Poverty Level Percentage
1	$ 11,170.00	$ 27,000.00	242%
2	$ 15,130.00	$ 19,000.00	126%
3	$ 19,090.00	$ 24,000.00	126%
4	$ 23,050.00	$ 35,000.00	152%
5	$ 27,010.00	$ 42,000.00	155%
6	$ 30,970.00	$ 65,000.00	210%
7	$ 34,930.00	$ 40,000.00	115%
8	$ 38,890.00	$ 56,000.00	144%

Determining Patients Poverty Level

- DHHS Federal Poverty Line Should be edited annually
- Patient income information can be entered into the corresponding cell (according to reported household)
- Embedded formulas will provide patient poverty level



	A	B	C	D	E	F
1		Determining Patient Poverty Level				
2						
3		Persons in Family/ Household	Poverty Guideline	Patient's Income	Poverty Level Percentage	
4		1	11170	27000	=D4/C4	
5		2	15130	19000	=D5/C5	
6		3	19090	24000	=D6/C6	
7		4	23050	35000	=D7/C7	
8		5	27010	42000	=D8/C8	
9		6	30970	65000	=D9/C9	
10		7	34930	40000	=D10/C10	
11		8	38890	56000	=D11/C11	
12						
13						
14						
15						
16						
17						
18						

Ryan White
Cap On Out Of Pocket Charges

- The law limits the annual cumulative charges to an individual for HIV-related services.
- Programs must have a system in place to ensure that these annual caps are not exceed.
- The grantee program does not have to collect proof of payment towards these out of pocket charges, only that the patient has charges equal to this threshold for HIV related medical services.
- Once the patient's charges have reached this threshold, the patient should not be charged for services for the rest of the patients enrollment year.

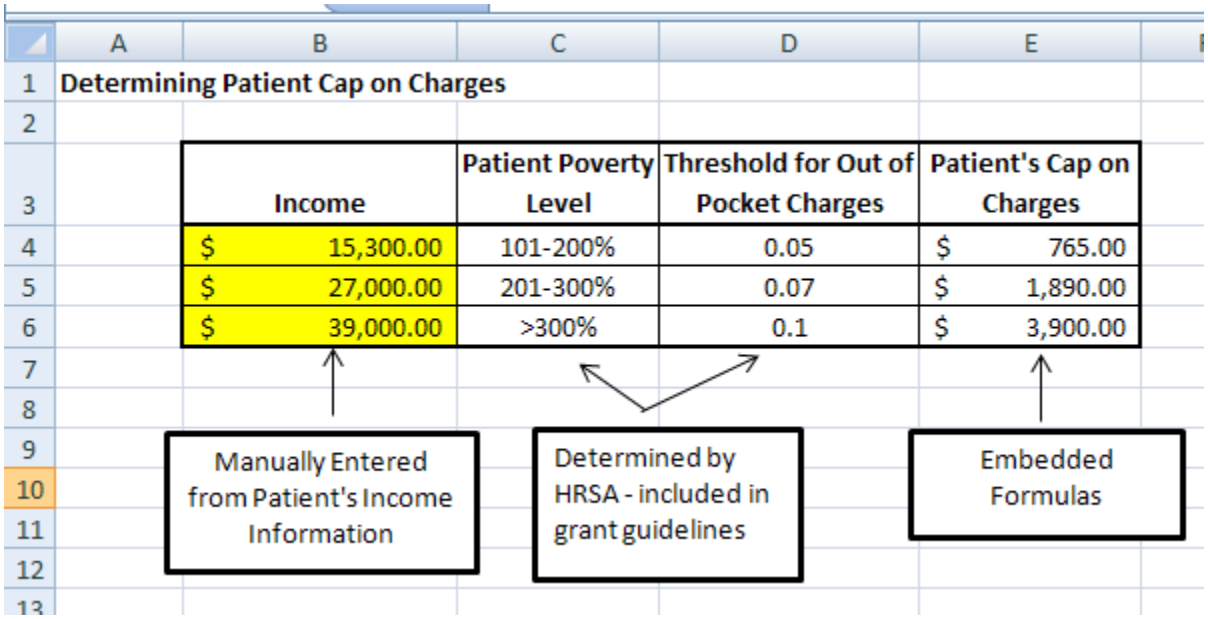
Ryan White
Cap On Out Of Pocket Charges*

- HRSA has identified thresholds, based on federal poverty level, that should not be exceeded.
- These thresholds range from 5%-10% of gross annual income

Individual Income	Maximum Charge
At or below 100% Poverty	$0
101% to 200% of Poverty	No more than 5% of gross annual income (money made before taxes and any other deductions are taken out)
201% to 300% of Poverty	No more than 7% of gross annual income
Over 300% of Poverty	No More than 10% of gross annual income

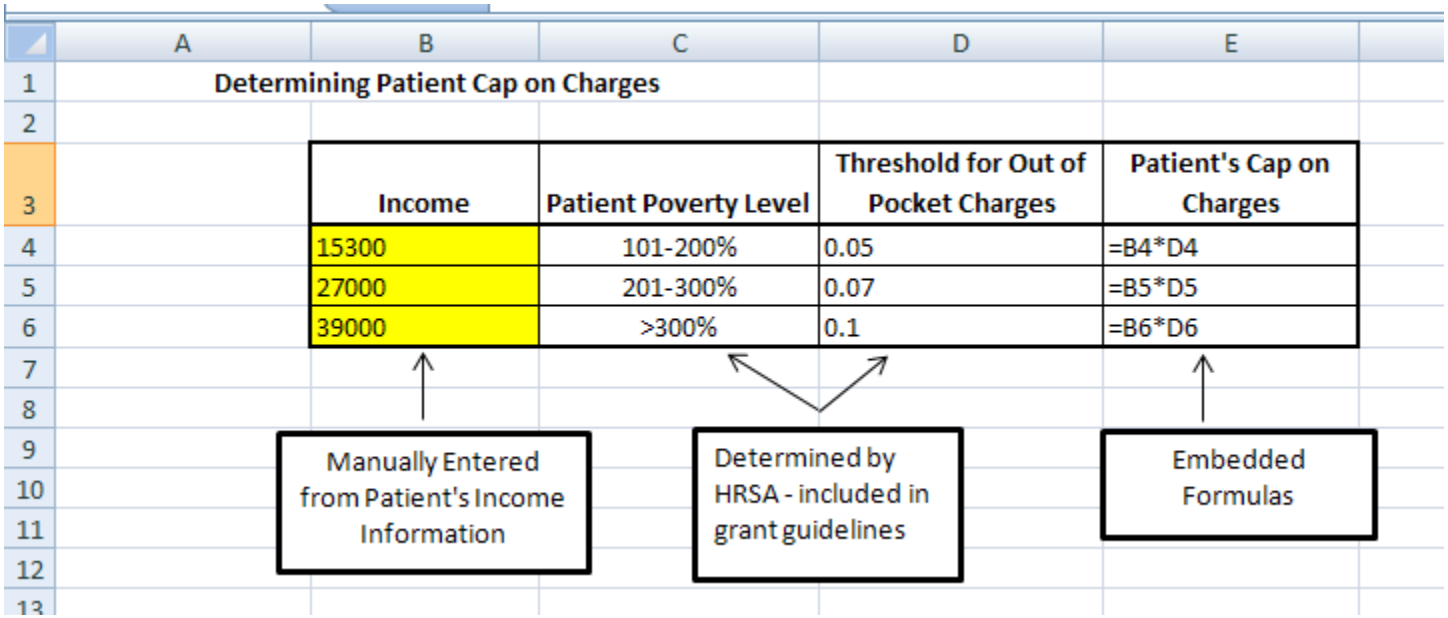
Determining Cap on Patient Charges

- Cap on Charges



Determining Cap on Patient Charges – Formula View

- Cap on Charges



Determining Cap on Out Of Pocket Charges

- Cap on out of pocket charges varies based on the patient's federal poverty level and is determined by taking the specified percentage of the patients gross annual income.
- Example 1– A single person household with an income of $27,000 would be 241% of the federal poverty level ($27,000 ÷ $11,170).
  - The cap threshold for persons with an income of 201-300% of the federal poverty level is 7% ($27,000 * 0.07 = $1,890). Once an enrolled patient has been charged $1,890 for medical services this patient should be covered at 100% for the rest of their enrollment year.

Determining Cap on Out Of Pocket Charges

- Example 2 – A three person household with the same income of $27,000 would be 141% of the federal poverty level ($27,000 ÷ $19,090).
  - The cap threshold for persons with income between 101-200% of the federal poverty level is 5% ($27,000 * 0.05 = $1350). Once an enrolled patient has been charged $1,350 for medical services this patient should be covered at 100% for the rest of their enrollment year.
  - If this family of three consists of more than one HIV positive person, the cap can be shared by the HIV-positive members of the household. Therefore, once the enrolled patients have been charged $1,350 for medical services these patients should be covered at 100% for the rest of their enrollment year.

Ryan White Program Expectations Patient Payment for Services

- In order to comply with these requirements programs should:
  - Provide staff training to enroll annually and reassess every 6 months
  - Develop patient education materials on availability of services and discounts available
  - Place notices in patient waiting rooms and reception areas detailing the sliding fee scale and cap on out of pocket charges
  - Have a system in place to collect patient's progress towards out of pocket cap and to adjust patient's responsibility based on this cap.

Enrolling Patients, Collecting Client Level Financial Data, and the Sliding Fee Scale

Ryan White Service Report Client Level Data Reporting

- The goal of client level reporting is to provide data on characteristics of funded grantees, providers, and the clients served with program funds.
- Data Submitted is used to
  - Monitor outcomes achieved on behalf of HIV/AIDS clients and their affected families receiving care and treatment through Ryan White grantees/providers
  - Address the disproportionate impact of HIV in communities of color by assessing organizational capacity and service utilization in minority communities
  - **Monitor the use of Ryan White funds** for appropriately addressing the HIV/AIDS epidemic in the US

Reasons to Collect Client Level Data

- Grant Requirement
- Tracks Spending per Patient
  - Gives realistic picture of spending based on client needs
  - Useful for forecasting based on disease status/insurance status
- Insurance status
  - Verify that billing agency has patient insurance information
  - Verify that insurance (if applicable) was charged first
  - Identify if charge was denied by insurance to determine if it was a coding issue

Reasons to Collect Client Level Data

- Sliding Fee Scale Billing/Cap Determination
  - Adhere to Legislative Guidelines
  - Key to ensuring that tight dollars are spread across patient population
  - Verify Correct Patient Federal Poverty Level
  - Ensure correct billing assignment (Grant vs. Patient Responsibility)
  - Generate Program Income
- Address Patient Questions
  - Have resource to address patient billing questions.
  - Can address patient questions as to why bill was received, what their responsibility is, etc.

Financial Tools/Processes

- Patient Enrollment Form and Process for enrollment and reassessment
- Sliding Fee Scale Level/Cap Chart – should be available to clients and posted in the clinical care area
- Patient Management Spreadsheet/Insurance Cards
- Patient Records/Federal reporting Database

Financial Tools Process
Ryan White Enrollment

Patient Enrolls/Recertifies Annually

Patient is assigned a Level on sliding fee scale based on information provided

Patient Information is entered on to patient/client spreadsheet

Spreadsheet is updated weekly and sent to grant/billing personnel

Financial information is updated in Patient Records Database

All bills for patients that qualify for the RW grant are sent to program manager

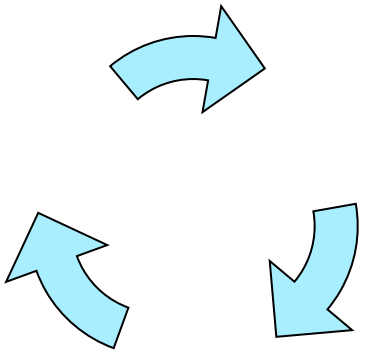
Program Manager designates grant/patient payment based on assigned level

Billing info is entered into patient database and sent to billing agency for formal billing

Patient/grant is billed based on level assignment

Check Number is entered into database, Patient payment is entered towards cap.

Patient cap is monitored and reassessed at 6 month assessment, Patient level is adjusted as needed.



Patient Management Spreadsheet

- Prepare a patient spreadsheet that tracks each patients level and cap on charges
- Indentify staff member(s) that can update/maintain this spreadsheet as a working tool for registration, billing, and program management
- Consider Insurance type cards to aid in appropriate billing and charges.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**Patient Name**	**MRN**	***OK TO BILL***	***RWC Exp. Date***	**Care District**	**RWD Eligible**	**2009 Level**	**2010 Level**	**Cap**	**FAP sent to UKFC**	**FAP Expiration**	**Insurance**	**Comments**
2	**Patient A**	**XXXXXXX**	***10/01/09***	***10/02/10***	**F**	**N**	**1**		**$0**				**Approved 2009**
3	**Patient B**	**XXXXXXX**	*06/25/09*	**06/26/10**	3	N	**1**		$0		7/1/1900	BCBS	Approved 2009
4	**Patient C**	**XXXXXXX**	08/05/08	**08/06/09**	C	N			$0	8/13/2008	2/12/2009	Medicare/QMB	Approved 2008
5	Patient D	**XXXXXXX**	12/08/09	12/09/10	3	Y	**1**		$0	5/21/2010	11/20/2010		Approved 2009
6	**Patient E**	**XXXXXXX**	05/02/07	**05/02/08**	F	N			$0	5/2/2007	11/1/2007		To provide por 2010
7	**Patient F**	**XXXXXXX**		**12/31/00**	3	N					7/1/1900		To provide poi for 2007.
8	Patient G	**XXXXXXX**	09/04/09	09/05/10	F	N	**6**		$3,478		7/1/1900	BC/BS	Approved 2009
9	Patient H	**XXXXXXX**	04/01/10	04/02/11	F	N		**1**	$0	5/21/2010	11/20/2010		Approved 2010
10	**Patient I**	**XXXXXXX**	02/09/09	**02/10/10**	F	N	**1**		$0	3/13/2009	9/12/2009		Approved 2009
11	Patient J	**XXXXXXX**	03/19/10	03/20/11	F	N	3	3	$894		7/1/1900	Medicare	Approved 2010
12	Patient L	**XXXXXXX**	10/27/09	10/28/10	F	N	**1**		$0	4/13/2010	10/13/2010		Approved 2009
13	Patient M	**XXXXXXX**	03/26/10	03/27/11	F	N		**6**	$4,004			Medicare/UMR	Approved 2010

Patient Levels
Grant/Patient Responsibility

- Patient Level is determined by the patient's identified federal poverty level based on submitted income information: two consecutive pay stubs, disability award letter, previous year tax form
- Patient pays a portion of medical costs or set co-pay based on their level

Client Assistance Based on Assigned Level

- Example 1 – Set co-pay is determined by program based on service expenses and care provided.
  - A nominal fee is charged for a medical care visit – amount varies based on patient's federal poverty level status

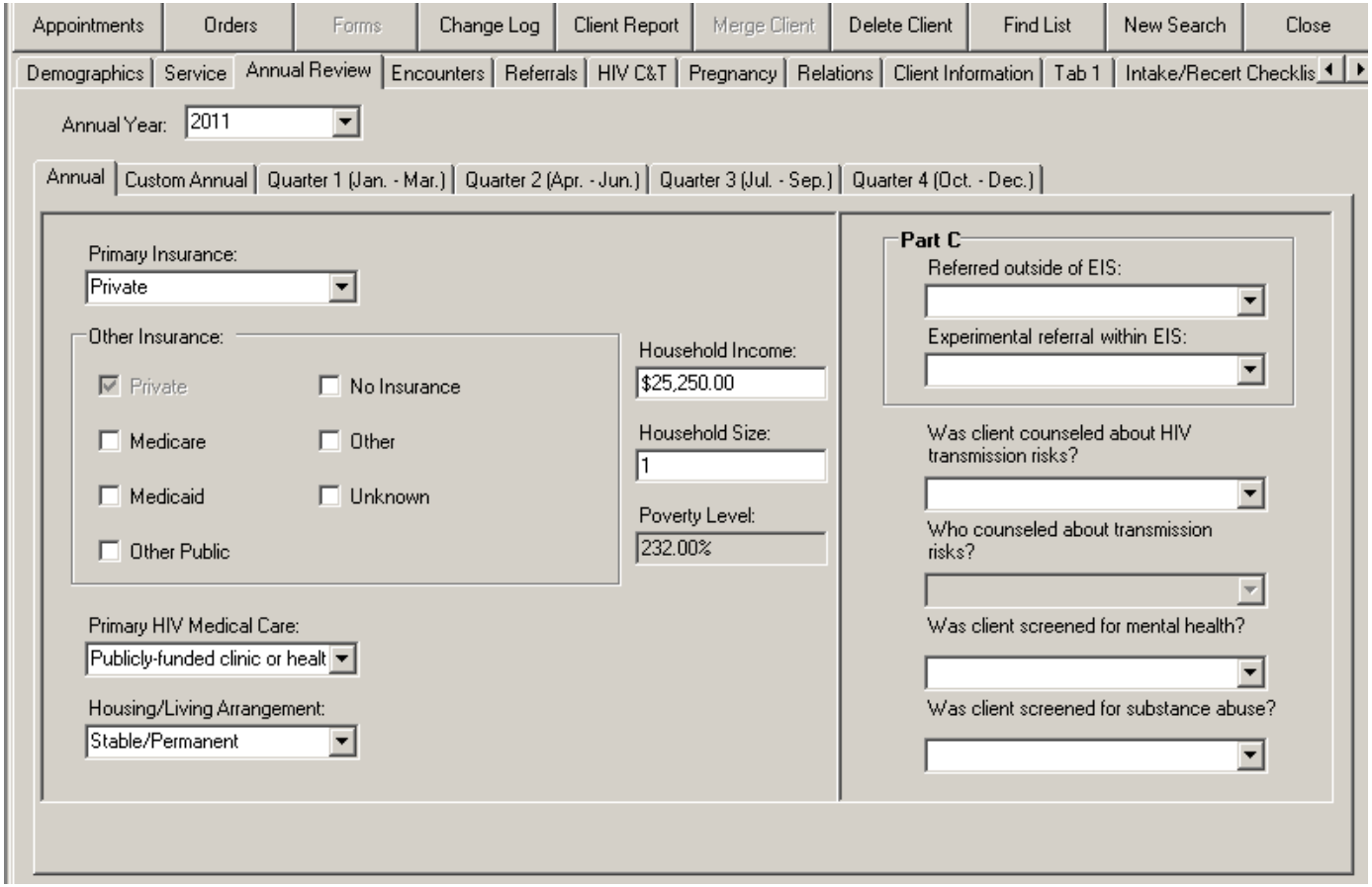
Level	Poverty Level	Grant Responsibility	Patient Responsibility	Co-Pay
1	<100% federal poverty level (FPL)	100%	0%	$0
2	101-150% of FPL	80%	20%	$5
3	151-200% of FPL	60%	40%	$10
4	201-250% of FPL	40%	60%	$15
5	251-300% of FPL	20%	80%	$20
6	>300% of FPL	0%	100%	$25

Client Assistance Based on Assigned Level

- Example 2 – Paying on a percentage
  - For a billing system that can accommodate percentage payments
    - Program helps Level 4 patient pay for Bactroban ($42.24) – Patient pays $15.84, grant pays $26.40
  - For a billing system than can't accommodate billing on a percentage.
    - Program helps Level 3 patient (Patient has 40% responsibility) pay for medicine co-pays at $30 per month. Pharmacy is unable to charge based on percentage. The program pays two months and patients pays for the third month, etc.

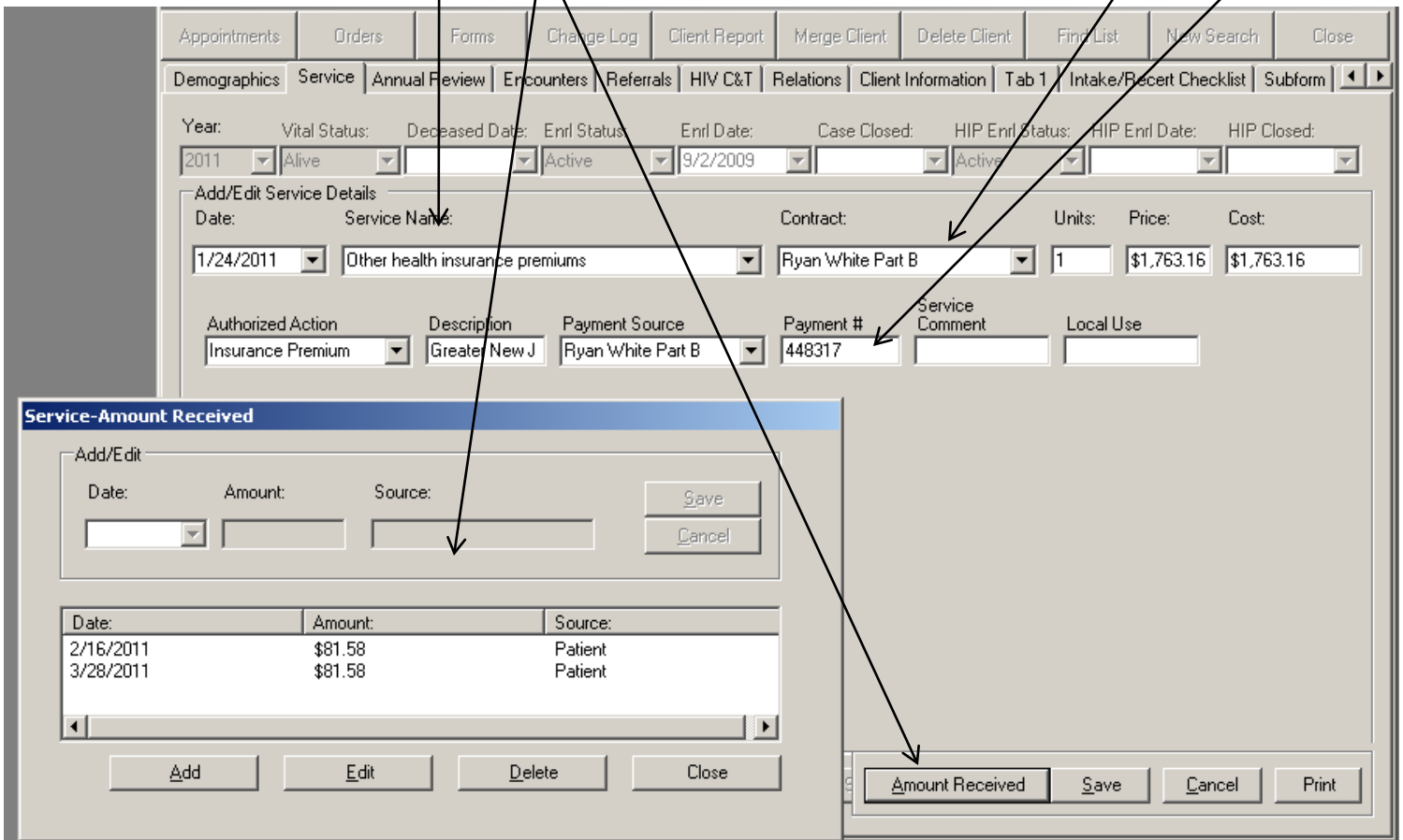
CareWare - Financial Tracking Tools

- Client Financial Information can be entered into Care Ware for reporting purposes



CareWare – Financial Tracking Tools

- Data Reporting (Cost Category); Payment Information; and Patient contribution is entered into CareWare



Evaluation of Client Level Financial Tracking

- Reporting allows you to track expenditures by grant, doctor, specialty, etc. (as specific as you want to be)
- Determine if funds are being used effectively per specialty, consider alternate referrals/programs, grants to apply for to help with costs…
- Consider negotiating cheaper rates if possible for multiple referrals to one specialty
- Determine costs per quarter to forecast expenditures, to ensure grant funds are being used effectively

CASE STUDIES

Case Study Tools

DHHS 2012 Poverty Level
http://aspe.hhs.gov/poverty/12poverty.shtml

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

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7	34,930
8	38,890
For families/households with more than 8 persons, add $3,960 for each additional person.	

* Web-site has more specific information for Hawaii & Alaska

Case Study Tools

Sliding Fee Scale – Un-Insured Patients

Level	Federal Poverty Level (FPL)	Patient Sliding Fee Scale Co-Payment	Cap on Charges
1	<100% FPL	$0	$0
2	101-150% FPL	$10	5% of Income
3	151-200% FPL	$20	5% of Income
4	201-250% FPL	$30	7% of Income
5	251-300% FPL	$40	7% of Income
6	>300% FPL	$50	10% of Income

Insured Patient Assumptions

$20 Co-Pay Time of Visit – Patient Income

$50 Insurance Payment for Visit – Third Party Income

Case Study 1

- Patient A is a single male that enrolls in your program on February 1st 2012. Patient has a monthly gross income of $2700. Patient does not have insurance available through work, but he pays for a private insurance policy for $248/month.
- Patient's HIV is relatively under control and is seen every 4 months in the clinic, patient must pay a $20 co-pay for visits (February, June, October).
- Patient does have related cholesterol issues so he sees a primary care doctor on-site every three months (February, May, August, November).

Case Study 1

- Patient's insurance requires that he pay a portion of his medication, which costs an average of $180/month.
- At the patient's August appointment he meets with the financial counselor to evaluate his progress towards meeting his out of pocket cap (6 month assessment).

Case Study 1

- Given the provided information, and the information on the tools below, please complete the information below.
- Patient Income: _____
- Federal Poverty Level (Income ÷ Poverty Level): _____
- Cap on Out of Pocket Charges (5%, 7%, or 10% of Income): _____
- Current Progress Towards Cap: _____
- Program Income for Ryan White Program: _____

Case Study 1

- Given the provided information, and the information on the tools below, please complete the information below.
- Patient Income: _$32,400_____
- Federal Poverty Level (Income ÷ Poverty Level): __290%_____
- Cap on Out of Pocket Charges (5%, 7%, or 10% of Income): _$2268_____
- Current Progress Towards Cap:
  - $100 Co-Pay;
  - $1488 (insurance);
  - $1080 = $2668 – Patient Has Met Out of Pocket Cap _
- Program Income for Ryan White Program - $350
  - $100 Co-pays
  - $250 Insurance Payments

Case Study 2

- Patient B is a single mom with two children 10 and 12. She was enrolled into the program in June 2012.
- The patient is uninsured and has an income of $1800/month. The patient enrolled in the program with a low CD4 count and has been seeing the HIV doctor once a month (June, July, August, September, October, November, December).

Case Study 2

- Based on the sliding fee scale below the patient must pay a $10 co-pay per office visit. The patient is enrolled in the AIDS Drug Assistance program, and receives assistance from Pharmaceutical Assistance Programs for other needed prescriptions.
- At the patient's December appointment Patient B brought in a bill for $600 for a recent emergency room visit. Patient B meets with the financial counselor to determine her progress in meeting her cap (6 month assessment).

Case Study 2

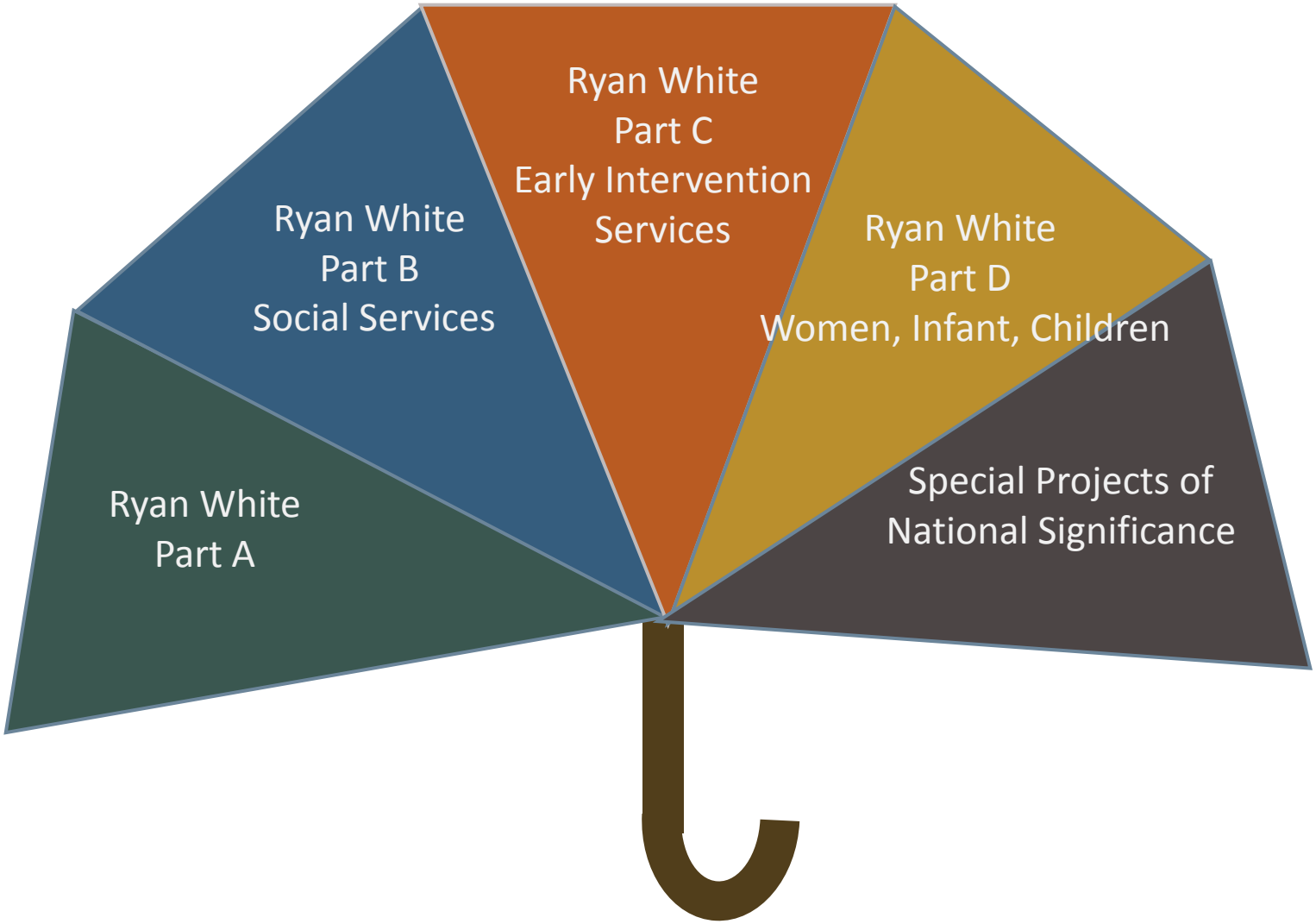
- Given the provided information, and the information on the tools below, please complete the information below.
- Patient Income: _____
- Federal Poverty Level (Income ÷ Poverty Level): _____
- Cap on Out of Pocket Charges (5%, 7%, or 10% of Income): _____
- Current Progress Towards Cap: _____
- Program Income for Ryan White Program: _____

Case Study 2

- Given the provided information, and the information on the tools below, please complete the information below.
- Patient Income: _$21,600_____
- Federal Poverty Level (Income ÷ Poverty Level): __113%_____
- Cap on Out of Pocket Charges (5%, 7%, or 10% of Income): __$1,080_____
- Current Progress Towards Cap - $670
  - $70 appt co-pays
  - $600 ER bill
- Program Income for Ryan White Program - $70
  - $70 appt co-pays

Using Enrollment and Eligibility to Manage Multiple Funding Streams

Supporting the Same Population with Multiple Funding Streams

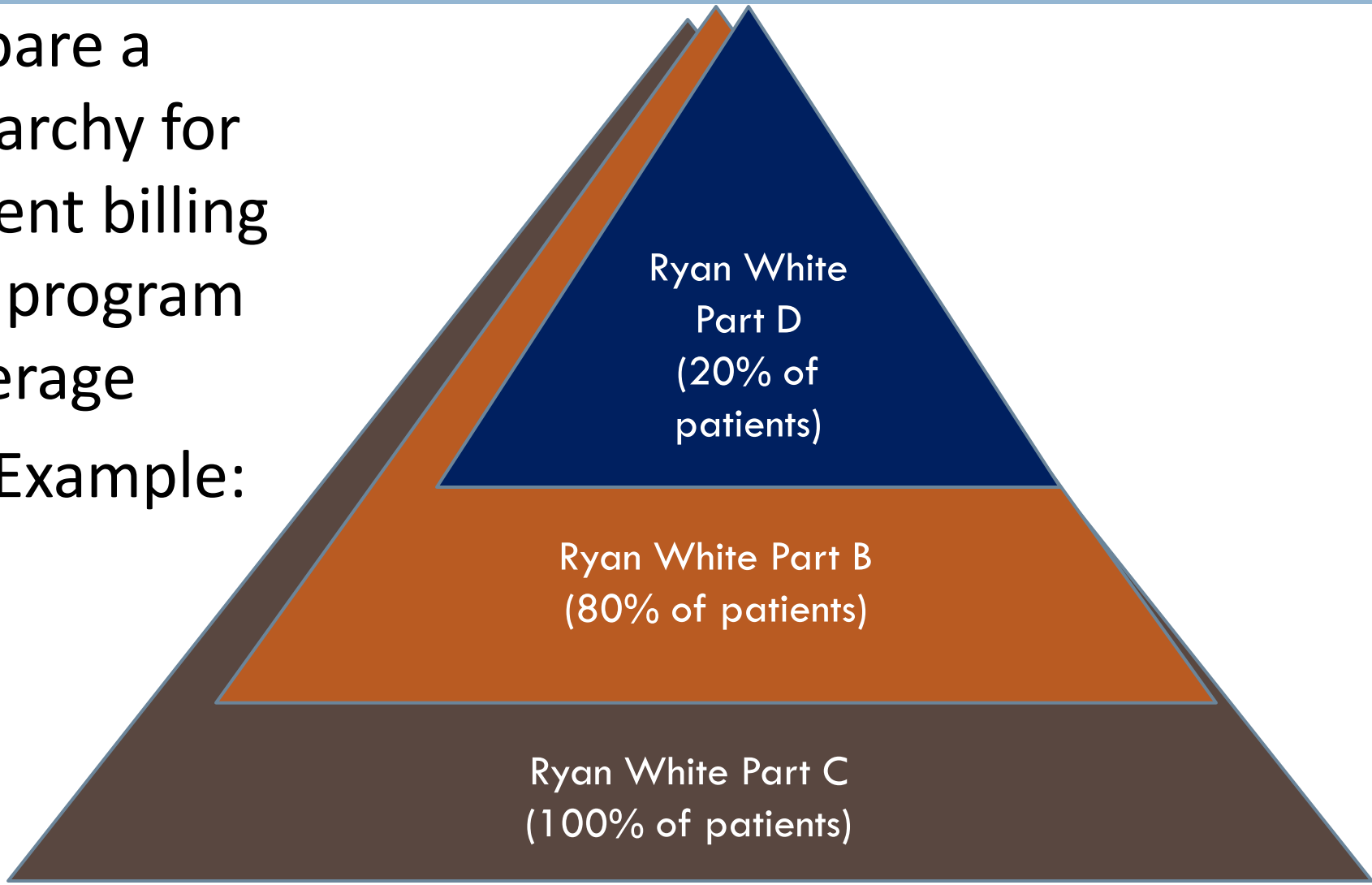


Supporting the Same Population with Multiple Funding Streams

- Review your patient population and identify how many active patients are eligible for each funding source.

Supporting the Same Population with Multiple Funding Streams

- Prepare a hierarchy for patient billing and program coverage
- For Example:



Supporting the Same Population with Multiple Funding Streams

- Prepare a Flow Chart or Table the identifies what each grant is allowed to pay for to ensure the funds are utilized correctly

Grant Coverage – Summary

All Female Clients & All Male Clients 24 yrs. and younger		
Part B	**Part C**	**Part D**
• Case Management Services • KADAP • Insurance Continuation Program	• HIV Specialty Care (Physicians - Hoven, Greenberg, Schaninger) • Primary Care (Hoellein)	• HIV Specialty Care (Physicians - Thornton, Murphy) • Primary Care (Mullen & Cary) • Specialty Care Referrals • Laboratory, Radiology, & Diagnostic Testing • Transportation Assistance • Pharmaceutical Assistance • Mental Health Counseling • Nutrition Counseling • Nutrition Supplements • Pharmaceutical Counseling • Durable Medical Equipment • Patient Parking • Lunch Vouchers • Hygiene Vouchers • Support Groups • Child Care for Medical Appts.

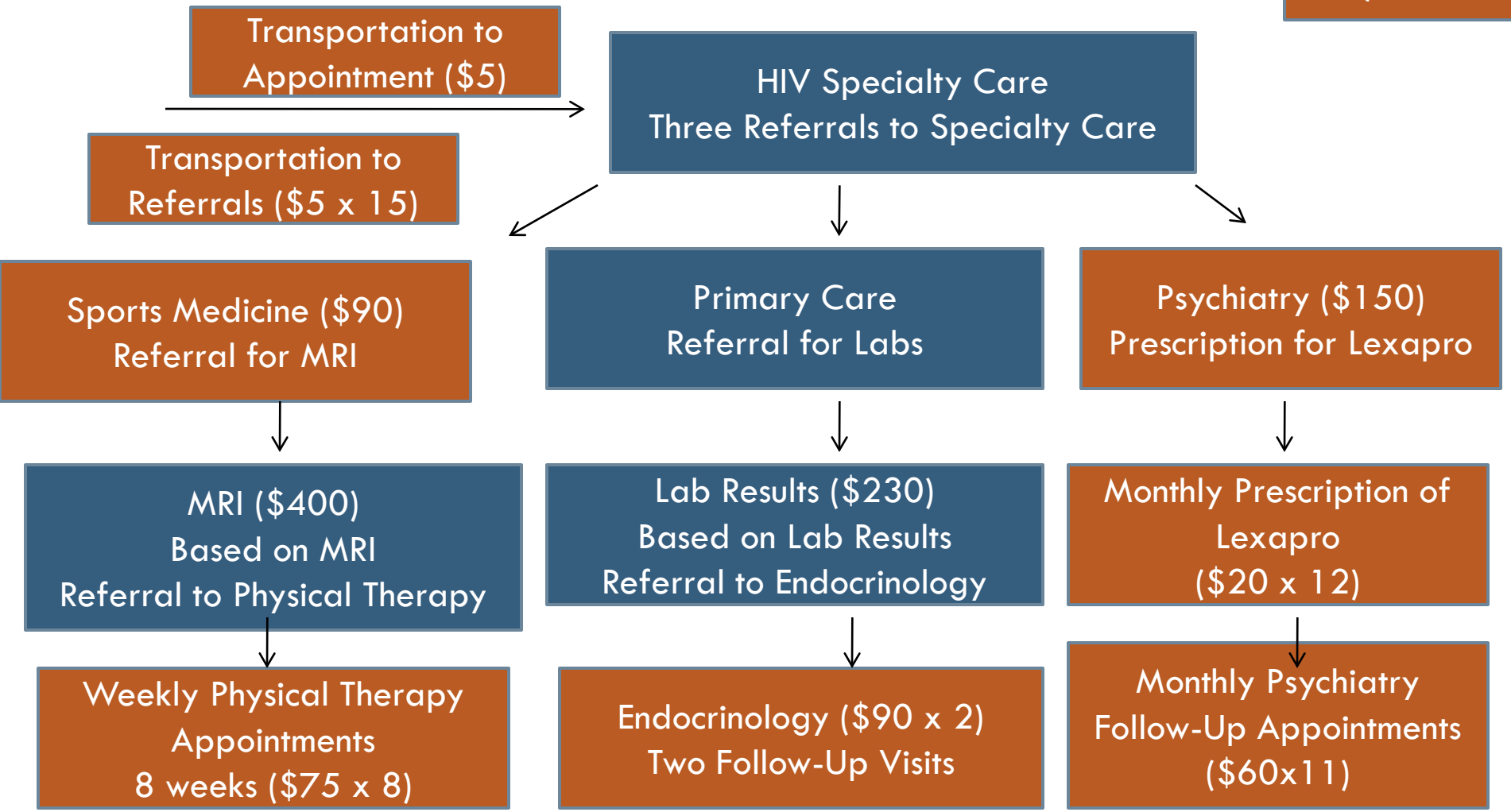
Grant Coverage – Summary

Part B/C Eligible Patients All Male Clients 25 years and older	
Part B	**Part C**
• Case Management Services • KADAP • Insurance Continuation Program • Transportation Assistance • Nutrition Supplements • Pharmaceutical Assistance • Specialty Care Referrals • Mental Health Counseling • Durable Medical Equipment • Patient Parking	• HIV Specialty Care • Primary Care • Laboratory, Radiology, & Diagnostic Testing • Nutrition Counseling • Pharmaceutical Counseling

Grant Coverage – Case Study
Male, 46, Level 1, Jessamine County Resident
Part B & C Eligible

Part C Funding $630.00

Part B Funding $2,000.00



Resources

- Ryan White Part D Competitive Guidance
- Ryan White Part C Competitive Guidance
- Ryan White Part A & B Monitoring Standards:

http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringparta.pdf

http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf

- RSR Instruction Manual

http://hab.hrsa.gov/manageyourgrant/files/rsrmanual.pdf

- About the Ryan White HIV/AIDS Program

http://hab.hrsa.gov/abouthab/aboutprogram.html

Questions?

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