2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Implementing HRSA/HAB Fiscal Monitoring Standards

Michael D. Shankle

Sr. Director of Capacity Building, HealthHIV

Fiscal Monitoring Standards

- Provide guidance for Ryan White recipients/subrecipients on HRSA/HAB expectations for grants management
- Outline fiscal management and compliance requirements
- Define performance measure, recipient responsibility, and subrecipient responsibility

Fiscal Monitoring Standards: Sections

A: Limitation on Uses of Funding

B: Unallowable Costs

C: Income from Fees for Services Performed

D: Imposition & Assessment of Client Charges

E: Financial Management

F: Property Standards

G: Cost Principles

H: Auditing Requirements

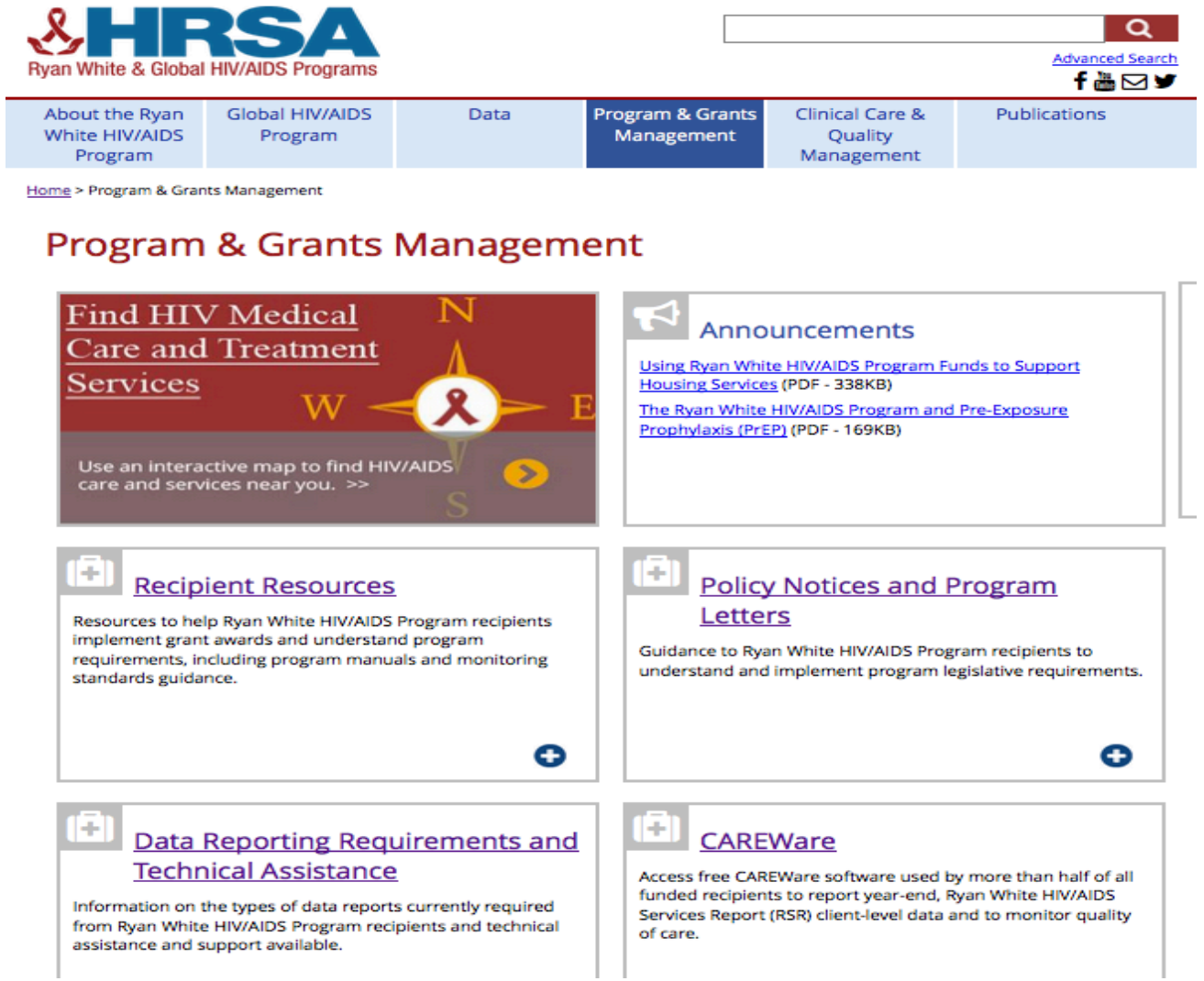
I: Matching or Cost-Sharing Funds

J: Maintenance of Effort

K: Fiscal Procedures

L: Unobligated Balances

HRSA Resources



https://hab.hrsa.gov/program-grants-management

Fiscal Monitoring Standards: Snapshot

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Section C: **Income from Fees for Services Performed**				
1. Use of Part B and other funding sources to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: • Medicaid • State Children's Health Insurance Programs (SCHIP) • Medicare (including the Part D prescription drug benefit) • Veteran's Administration, and • Private insurance (including medical, drug, dental and vision benefits)	• Information in client records that includes proof of screening for insurance coverage • Documentation of policies and consistent implementation of efforts to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance or other programs • Documentation of procedures for coordination of benefits by grantee and subgrantees	Establish and implement a process to ensure that subgrantees are maximizing third party reimbursements, including: • Requirement in subgrantee agreement or through another mechanism that subgrantees maximize and monitor third party reimbursements • Requirement that subgrantees document in client record how each client has been screened for and enrolled in eligible programs • Monitoring to determine that Ryan White is serving as the payer of last resort, including review of client records and documentation of billing, collection policies and procedures, and information on third party contracts	• Have policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met • Require that each client be screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage, with documentation of this in client records • Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payer is not available • Establish and maintain medical practice management systems for billing	PHS ACT 2617 (b) (iii) Funding Opportunity Announcement

HRSA/HAB Division of State HIV/AIDS Programs
National Monitoring Standards - Fiscal Part B April 2013

Fiscal Monitoring Standards: Ryan White Parts

- Fiscal monitoring standards were developed for Parts A & B.
- Differences between A & B:
  - Part A administrative costs cannot exceed **10%**
  - Part B administrative, planning and evaluation costs cannot exceed **15%**
  - Part B includes ADAP-specific regulations

Limits on Administrative, Planning/Evaluation, & Quality Improvement Costs

- *Policy Clarification Notice 15-01* defines administrative costs
- Administrative costs cannot exceed 10% of the award
- Planning and evaluation costs **also** cannot exceed 10% of the award
- The TOTAL of these two (administration and planning & evaluation) cannot exceed 15% of the total award
- Quality improvement costs are limited to an ADDITIONAL 5% (up to $3 million)

Subrecipient Administrative Costs

- **Aggregate** subrecipient administrative costs are limited to 10% of the total service dollars awarded to subrecipients.
- Subrecipient (service provider) administrative costs include:
  - Usual and recognized overhead activities
  - Management oversight
  - Other program support
  - All indirect costs charged by subrecipients

Subrecipient Administrative Costs

- Part B recipients must ensure that the aggregate total of subrecipient administrative expenditures does not exceed 10% of the aggregate total of funds awarded to subrecipients
- Subrecipient administrative expenses may be individually set and may vary

Policy Clarification Notice 15-01

- Provided more flexibility with administrative costs
- Some costs previously considered administrative can be charged to relevant service categories
- Examples: rent on areas utilized for service delivery, costs of recertification, EMR fees and services, setting appointments, medical billing costs, quality assurance supervision of services, recipient (not subrecipient) indirect
- Must relate back to delivery of a Ryan White-defined service

75%/25% Rule

- No less than 75% of service dollars must be expended for core medical services
- No more than 25% of service dollars may be expended for support services
- HRSA defines support and core medical services in Policy Clarification Notice 16-02
- Recipients may request a waiver for this rule IN ADVANCE

Waiver of the 25% Limit (PCN 13-07)

- Waiver request may be submitted anytime before application or up to 4 months after the start of the grant year
- Conditions must be documented:
  - No current or anticipated ADAP waiting list
  - All core medical service are available to clients within 30 days
  - Public process supports the waiver
  - Narrative explanation

Unallowable Costs, Part 1

- Cash payments to service recipients, including cash incentives
- Medical or other care provided in a hospital, emergency room, or other inpatient basis.
- Clothing
- Funeral, burial, cremation or related expenses
- Local or State personal property taxes
- Foreign travel
- Purchasing or improving land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling)
- Non-targeted marketing promotions or advertising about HIV services that target the general public
- Broad-scope awareness activities about HIV services that target the general public
- Pre-exposure prophylaxis
- Maintenance of a privately owned vehicle lease or loan payments, insurance, or license and registration fees
- Costs to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs

Unallowable Costs, Part 2

- Outreach activities that have HIV prevention education as their exclusive purpose
- Influencing or attempting to influence members of Congress and other Federal personnel
- Creation, capitalization, or administration of a liability risk pool or any amount expended by
  a State under Title XIX of the Social Security Act (Medicaid)
- Criminal defense or class-action suits unless related to access to services eligible for RW funding
- Developing materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual
- No use of Part B funds for the purchase of vehicles without written Grants Management Officer (GMO) approval

Unallowable Costs, continued

- Recipients should maintain a list of allowable and unallowable costs
- Make this list available for subrecipients and include in communications (subrecipient agreements) with subrecipients

Income from Fees for Services Provided

Program income is “gross income received by the recipient or subrecipient directly generated by a grant supported activity, or earned only as a result of the grant agreement during the grant period.”

45 CFR §92.25

Examples of Program Income

- Amounts billed and collected from Medicaid, Medicare or other third party payers
- Fees collected from clients
- Revenue generated from 340B pharmacy program

Tracking and Reporting Program Income

- Ryan White recipients must report their program income in aggregate in the Federal Financial Report (program income **earned** in line n and **expended** in line l) and annual data report
- If a subrecipient has program income, it must be tracked and reported to the recipient

Uses of Program Income

- Service providers must retain their program income and must use it for program purposes
- Recipients must monitor subrecipient *receipt* and *use* of program income to ensure it is being used for program activities

Payer of Last Resort

Ryan White “funds may not be used when payment has been made or can reasonably be expected to be made” under any State compensation program, under an insurance policy, or under any Federal or State health benefits program.

Part A: 42 U.S.C.A. § 300ff-15 (a)(6)

Part B: 42 U.S.C.A. § 300ff-27 (b)(7)(F)

Implementing Client Charges

Ryan White legislation mandates that the provider:

- Will not impose a charge on individuals with incomes at or below 100% of the federal poverty level (FPL) for the provision of Ryan White services
- Will impose a charge on individuals with incomes above 100% FPL for the provision of Ryan White services according to a schedule of charges that is made available to the public

Public Health Service Act Sec. 2605(e)

Imposition of Client Charges

- Recipients must implement a process to ensure that subrecipients are **maximizing third party reimbursements** (to demonstrate that Ryan White is the payer of last resort)
- Subrecipients must implement a schedule of charges for Ryan White services, based on income:
  - Ryan White program eligibility is based on ***household*** income
  - Schedule of charges is based in ***individual*** income

Fiscal Monitoring Standards: Imposition of Client Charges

1. Ensure recipient and subrecipient policies and procedures require a publicly posted schedule of charges (e.g. sliding fee scale) to clients for services, which may include a documented decision to impose only a nominal charge

Fiscal Monitoring Standards, Section D

Schedule of Charges: Provider Responsibility

Establish, document, and have available for review:

- Policy for a schedule of charges
- Current schedule of charges
- Client eligibility determination in client records
- Fees charged by the provider and the payments made to that provider by clients
- Process for obtaining and documenting client charges and payments made during the calendar year (January – December) through an accounting system

Schedule of Charges: Clients Below 100% FPL

2. No charges imposed on clients with incomes below 100% of the Federal Poverty Level (FPL)

Clients Below 100% FPL: Provider Responsibility

Document that:

- Policy for schedule of charges does not allow clients below 100% of FPL to be charged for services
- Personnel are aware of and consistently following the policy for schedule of charges
- Policy for schedule of charges must be publicly posted

Client Charges

Providers are limited in the amounts they are allowed to charge clients.

Client Annual Income	Limit on Charges
Less than 100% of Federal Poverty Level	NO CHARGES ALLOWED
101% - 200% of FPL	No more than 5% of Annual Income
201% - 300% of FPL	No more than 7% of Annual Income
More than 300% of FPL	No more than 10% of Annual Income

These limits are ACROSS PROVIDERS. If clients demonstrate they have reached their annual limit, NO Ryan White funded provider should impose further charges.

Clients Above 100% FPL: Provider Responsibility

Establish and maintain a schedule of charges policy that includes a cap on charges and the following:

- Responsibility for client eligibility determination to establish individual fees and caps
- Tracking of charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc.
- A process for alerting the billing system that the client has reached the cap and should not be further charged for the remainder of the calendar year
- Personnel are aware of and consistently following the policy for schedule of charges and cap on charges

Complying with Schedule of Charges Requirement

- Establish program-specific policies and procedures
- Provide and document additional staff training
- Develop patient education materials

Program Expectations: Schedule of Charges

- Each program is responsible for creating its own schedule of charges in accordance with Ryan White statutory requirements
- Federal Poverty Guidelines are updated each year in late winter and are available on the HHS website

https://aspe.hhs.gov/poverty-guidelines

Fiscal Monitoring Standards: Clients Above 100% FPL

3. Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (i.e. caps on charges) for Ryan White services are based on the percent of client's annual income, as follows:

- 5% for clients with incomes greater than 100% and not exceeding 200% of FPL
- 7% for clients with incomes greater than 200% and not exceeding 300% of FPL
- 10% for clients with incomes greater than 300% of FPL

Caps on Charges

- Each Ryan White program must have a system in place to ensure that these annual (calendar year) caps on charges to patients are not exceeded
- Organization must track the patient's annual gross income and charges imposed (cap on charges)
  - The patient tracks charges imposed across programs

Public Health Service Act Section 2605e

Caps on Charges, continued

Patient caps on charges are:

- Based on an individual's FPL
- Calculated and updated annually
- Based on charges imposed, not on payments made
- Applied to both insured and uninsured patients (remember payer of last resort policy)

Caps on charges should consider the annual aggregate of charges imposed without regard to whether they are characterized as enrollment fees, premiums, deductibles, copayments and coinsurance (PCN 13-05, 13-06, 14-01)

Caps on Charges, continued

- Providers must publicly post their schedule of charges
- If a provider charges any fees to any clients, they must also impose a fee for clients over 100% of FPL (may be nominal)
- This must be monitored by the recipient

Accounting and Audit Guidelines

- Must demonstrate that fiscal management adheres to federal regulations: systems, policies, budgets, procedures, reports, and records
- Budgets must include the applicable HRSA categories: Administrative, Planning & Evaluation, Clinical Quality Management, HIV services, ADAP (for Part B) and Minority AIDS Initiative funding

Accounting and Audit Guidelines

Significant budget modifications must be pre-approved by HRSA:

- If cumulative transfers among direct budget categories exceeds 25% of total approved budget OR $250,000 (whichever is less)
- If the re-budgeting involves a change in scope
- If the re-budgeting involves a purchase of a unit of equipment exceeding $25,000

Note: Subrecipients may be provided more restrictive guidance

Accounting and Audit Guidelines

- Subrecipient agreements must include the provisions required by HRSA and must follow state law and procedures
- If a program acquires a unit of property costing $5,000 or more, it must be tracked and reported, and HRSA retains “reversionary interest”
- Reimbursements to contractors should be paid within 30 days if accurate and complete

Cost Principles

- Payments to subrecipients must be cost-based and be in accordance with federal guidelines
- Payments for services and medication must be reasonable (compared to prevailing pricing)
  - This also applies to unit costs, which must not exceed actual costs
- For ADAP, cannot exceed 340B pricing plus reasonable fees. Must pursue best pricing and all available drug rebates
- Cost of health insurance assistance, in aggregate, cannot exceed the cost of providing the medications through ADAP

Audit Guidelines

- Subrecipients that receive more than $750,000[1] in aggregate federal funding must have a Single Audit (formally A-133 Audit)
- Reportable conditions must be conveyed to HRSA with a resolution plan
- For Part B, the recipient must collect all Single Audits of subrecipients and submit them to HRSA every two years

[1]Up from $500,000 due to the Super Circular

Match and Maintenance of Effort

- The Notice of Award (NoA) discloses if a program is subject to match requirements
- Will also disclose the ratio of match required (e.g., $1 of non-Federal for every $4 of Federal)
- Must ensure that the funding is not already used to match another award and is allowable for this purpose

Match and Maintenance of Effort

- Must demonstrate maintaining a level of state/local funding equal to the level in the year preceding the current year
- Cannot use Ryan White funding to supplant state/local funding
- Must use a consistent methodology

Unobligated Balances

- HRSA expects recipients to efficiently spend 95% of awards in any given grant year
- Can report up to 5% unobligated balance without penalty
- Penalties for excess unobligated balances: offset, reduction, ineligibility for supplemental

Uniform Guidance

2 CFR 200 *OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) was implemented by the Department of Health and Human Services (HHS) as 45 CFR Part 75 on December 26, 2014.

National Center for Healthcare Capacity Building

Syncing Innovative Approaches with Successful Outcomes

An Initiative of HealthHIV

- HIV Prevention Technical Assistance
- ASO/CBO Capacity Building
- ASO/CBO Leadership Initiative
- The BLT: Board Leadership Training
- Transforming from HIV Prevention Practice to Prevention Innovation
- Medication Therapy Management
- Fiscal Health Professional Services
- Telehealth: Building HIV Retention in Care Among Minority Communities

Visit www.HealthHIV.org/cba-center

Booth Number #30

FiscalHealth™
PROFESSIONAL SERVICES

HealthHIV's *Fiscal Health Professional Services*™ helps Ryan White programs build fiscal management capacity, improve organizational sustainability, and maintain compliance with federal guidelines. Content areas include:

- Managing 340B Pharmacy Programs
- Budgeting and Projecting Program Income
- Understanding Uniform Guidance for Federal Grants
- Budgeting for the Non-Financial Manager
- Responding to Audit/Site Visit Findings
- Implementing Sliding Fee Scales and Caps on Charges
- Complying with HRSA/HAB Fiscal Monitoring Standards
- Diversifying Income
- Maximizing Third-Party Billing
- Overseeing Federal Grants

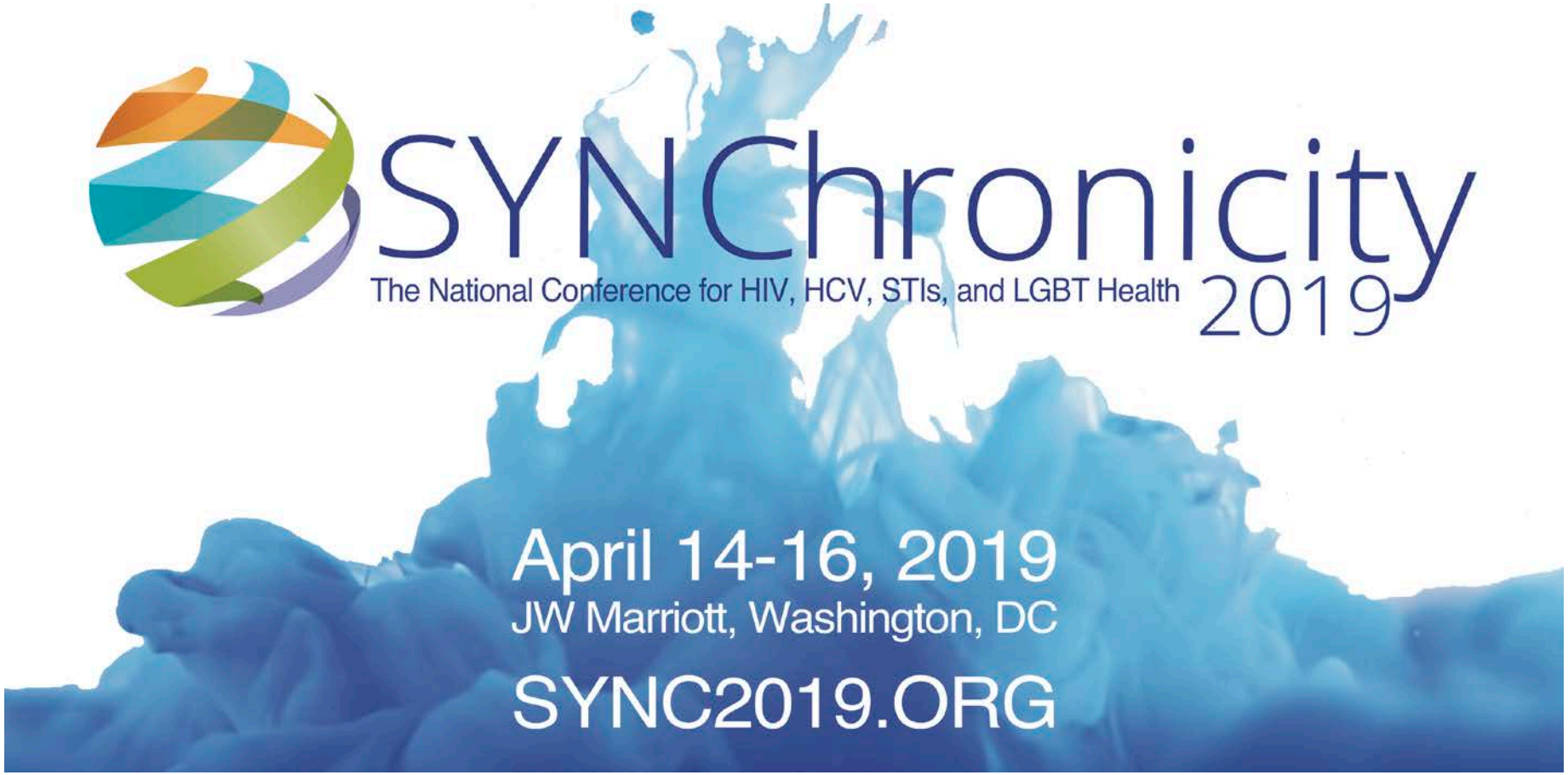
Contact Shayna Linov, Fiscal Health Manager, Shayna@HealthHIV.org, 202-507-4739

HealthHIV

HIV Primary Care Training & Certificate Program

- Online, self-paced, staged CME curriculum
- Features five courses on:
  - HIV Management in Primary Care - Foundations Course
  - Core Skills for HIV Management in the Primary Care Setting
  - Assessment and Treatment Decisions in HIV-HCV Co-infection
  - Considerations in the Management of HIV in Older Adults
  - Improving Communication in the Clinical Setting
- Based on a proven model of HIV primary care integration
- For MDs, DOs, NPs, and/or PAs interested in and/or care for patients infected with, or at-risk for, HIV
- Offers a certificate of proficiency in HIV primary care

Visit https://www.mycme.com/healthhiv/section/8086/



To register and for more information visit www.SYNC2019.com

Abstracts Due: Monday, December 17, 2018

Questions?

Contact

Michael D. Shankle

Michael@HealthHIV.org

Shayna Linov

Shayna@HealthHIV.org