Sliding Fee Scale & Cap on Patient Charges

Jana D. Collins, MS
May 19, 2016
Presentation Outline

• The Circle of Client Management
• Payment for Services
• Enrollment and Eligibility
• Sliding Fee Scale
• Cap on Out of Pocket Charges
Learning Objectives

By the end of this session, participants should be able to:

• Develop a sliding fee policy
• Implement a sliding fee policy
• Calculate the annual limitation of charges for patients based on income
The Circle of Client Management

- Tracking Program Income
- Enrollment & Eligibility
- Cap on Charges
- Sliding Fee/Discount Schedule
Definition of Key Terms

• **Program Expectations** – Information is typically found in the specified part’s Funding Opportunity Announcement or in Policy Notices and Program Letters

• **Legislation** – information is derived specifically from the Ryan White program legislation
The RWHAP legislation:

- Prohibits imposing a first-party charge on individuals with incomes at or below 100% of the federal poverty level (FPL); and
- Requires that individuals with incomes above the official poverty level be charged for services based on FPL
Programs must have consistent and equitable policies/procedures related to screening for eligibility for the RWHAP program which includes:

- Verification of patients' financial status;
- Implementation of a sliding fee scale;
- Ensuring a cap on patient charges for HIV-related services.
In order to comply with these requirements programs should:

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

- Ryan White legislation required that individuals receiving Ryan White Services must:
  - Have a diagnosis of HIV/AIDS and
  - Be low-income as defined by the grantee (PCN-13-02)

- Parts A & B Planning Bodies/Consortia may define eligibility more precisely (specified FPL) but may not broaden the definition (PCN 10-02)
Eligibility Policies and Procedures should include documentation of:

- Initially:
  - Clients’ HIV status
- Initially & Annually Thereafter:
  - Insurance Eligibility Assessment and/or Enrollment
  - Proof of Income
  - Family/Household Size (define household/individual)
  - Proof of Residency
Enrollment & Eligibility

- Assessment for eligibility should occur:
  - at intake
  - annually thereafter
  - And with an established process to recertify patients at 6 months.
## Enrollment & Eligibility Documentation (PCN 13-02)

<table>
<thead>
<tr>
<th></th>
<th>Initial Eligibility Determination &amp; Once a Year/12 Month Period Recertification</th>
<th>Recertification (Minimum of every 6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV Status</strong></td>
<td>Documentation required for Initial Eligibility Determination</td>
<td>No Documentation Required</td>
</tr>
<tr>
<td></td>
<td>Documentation is not required for the once a year/12 month period recertification</td>
<td></td>
</tr>
<tr>
<td><strong>Income &amp; Residency</strong></td>
<td>Documentation Required</td>
<td>Recipient may choose to require a full application and associated documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of no change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of change requires documentation</td>
</tr>
</tbody>
</table>
# Enrollment & Eligibility Documentation (PCN 13-02)

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<th>Recertification (Minimum of every 6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insurance Status</strong></td>
<td>Recipient must verify if the applicant is enrolled in other health coverage and document status in client file</td>
<td>Recipient must verify if the applicant is enrolled in other health coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-attestation of no change</td>
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<tr>
<td></td>
<td></td>
<td>Self-attestation requires documentation</td>
</tr>
<tr>
<td><strong>CD4/Viral Load</strong></td>
<td>Discretion of recipient</td>
<td>Discretion of recipient</td>
</tr>
</tbody>
</table>
Self Attestation – No Change

• Patient Identifies that there have been no significant changes to eligibility criteria:
  – Medical Insurance
  – Income
  – Residency
  – Household Size

• Form is signed to document that recipient completed 6 month recertification
Self-Attestation Statement of No Change

I ______________________________, declare that there has been no change in my:

☐ Medical Insurance
☐ Income
☐ Household Size
☐ Residency (Address)

Notes:

__________________________________________________________

In the future, should there be a change with any of the aforementioned criteria; I understand that I must notify the program immediately. If minor change mark the correct box and attached supporting documentation.

I understand I will be notified if any changes affect my eligibility.

Client Signature ___________________________ Date ________________

Witness (if client is unable to sign)
Self Attestation Of Change

- Recipient may require patient to complete full application and submit required application
- Patient Identifies that there has been a change(s) to eligibility criteria:
  - Medical Insurance
  - Income
  - Residency
  - Household Size
- Patient provides updated documentation
- Form is signed to document that recipient completed 6 month recertification
Self Attestation Of Change – Example, Part 1

Statement of Change Form

If you experience a change in any of the items listed below, please complete the section of this form that applies to your situation.

I ____________________________, declare that there has been a change in my
(print your name)

☐ Medical Insurance
☐ Income
☐ Household Size
☐ Residency (Address)

Notes:

☐ Medical Insurance
  My new insurance information is listed below:
  Insurance company: ____________________________
  Policy #: ____________________________
  A copy (both front and back) of my health insurance card is attached to this form.

☐ Income change
  I have experienced a change in household income. My new household income is
  $______________ per month.
  Please provide proof of this income.
Self Attestation Of Change – Example, part 2

☐ Household size change
There are now _____ persons in my household, including ____ persons under the age of 18, as of ____________________.

☐ Address change
I have moved. My new address is: ______________________________________

City: ___________________________ State: _____ Zip: ___________

Phone: (____) __________________
Please provide proof of this address.

_________________________________________  __________________________
Client Signature  Date

_________________________________________
Witness (if client is unable to sign)
The enrollment and eligibility process is key to:

- Identifying the patient’s placement on the sliding fee scale
- Applying the pre-determined discount on charges
- Determining the patient’s cap on out-of-pocket charges
Sliding Fee Scale/Discount Schedule

Enrollment & Eligibility

Sliding Fee/Discount Schedule
Clients cannot be denied RWHAP services if they are not able to pay for services.

Ryan White programs must provide a system to track the patient’s income and discount patient payment for charges by developing and utilizing a sliding discounted fee schedule that is published and made readily available.

The Fee schedule may be based on patient’s income or income and household size.
Ryan White Program Expectations: Sliding Fee Scale

• Each program is responsible for creating its own sliding fee scale in accordance with the most recent Federal Poverty Level guidelines

• Federal Poverty Guidelines are updated each year in late winter and are available on the web (HHS web-site)
## 2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in Family/Household</th>
<th>Poverty Guideline</th>
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<tbody>
<tr>
<td>1</td>
<td>$11,880</td>
</tr>
<tr>
<td>2</td>
<td>16,020</td>
</tr>
<tr>
<td>3</td>
<td>20,160</td>
</tr>
<tr>
<td>4</td>
<td>24,300</td>
</tr>
<tr>
<td>5</td>
<td>28,440</td>
</tr>
<tr>
<td>6</td>
<td>32,580</td>
</tr>
<tr>
<td>7</td>
<td>36,730</td>
</tr>
<tr>
<td>8</td>
<td>40,890</td>
</tr>
</tbody>
</table>
• Often organizations will already have a defined sliding fee scale,
• ie. Community Health Center Regulations
  – Allow for a minimum charge/nominal fee for persons with income < 100% of FPL
  – Caps sliding fee discount to persons below <200% of the FPL
Ryan White & Other Sliding Fee Scales

- If the organizations existing sliding fee scale is in line with Ryan White Legislation and Program Requirements then recipients can utilize the existing sliding fee scale.
- However, if the sliding fee scale is not in compliance then the recipient will need to adopt a sliding fee scale specific to the Ryan White grant program.
- i.e. Community Health Centers must have a specific sliding fee scale unique to the Ryan White Program, since persons with incomes <100% of FPL cannot be charged for services.
Nominal Fee

• Nominal fee - minimal in comparison with real worth or what is expected
• Any type of small fee or charge can be referred to as a nominal fee
• There is no fixed definition of how much a nominal fee is
• Nominal fees can be flat rates or percentages, which means they can cover a wide range of actual costs
### Nominal Fee – Fixed Rate (Sample)

<table>
<thead>
<tr>
<th>Federal Poverty Level</th>
<th>Nominal Fee*</th>
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</thead>
<tbody>
<tr>
<td>&lt;100% FPL</td>
<td>$0</td>
</tr>
<tr>
<td>101-150% FPL</td>
<td>$5</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>$10</td>
</tr>
<tr>
<td>201-250% FPL</td>
<td>$15</td>
</tr>
<tr>
<td>251-300% FPL</td>
<td>$20</td>
</tr>
<tr>
<td>300% - 400% FPL</td>
<td>$25</td>
</tr>
<tr>
<td>&gt;400% FPL</td>
<td>Full Charge</td>
</tr>
</tbody>
</table>

* Up to the patient’s assigned cap on charges
Nominal Fee - Case Study 1

- Person living with HIV
- Annualized income = $14,916
- Household Size of 1
- FPL = 125%
- Patient has Medicare

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<thead>
<tr>
<th>Federal Poverty Level</th>
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</thead>
<tbody>
<tr>
<td>101-150% FPL</td>
<td>$5</td>
</tr>
</tbody>
</table>
Nominal Fee - Case Study 1

• Completes HIV-related medical appointment
• Patient responsibility after Medicare
  – Patient balance after Medicare = $51.25
  – Patient is charged nominal fee of $5
  – Grant assists patient with pays $46.25 out of pocket

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### Nominal Fee – Percentage of Charges (Sample)

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<tr>
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<td>40%</td>
</tr>
<tr>
<td>251-300% FPL</td>
<td>60%</td>
</tr>
<tr>
<td>300% - 400% FPL</td>
<td>80%</td>
</tr>
<tr>
<td>&gt;400% FPL</td>
<td>Full Charge</td>
</tr>
</tbody>
</table>

* Up to the patient’s assigned cap on charges
Nominal Fee – Case Study 2

- Person living with HIV
- Annualized income = $18,576
- Household Size of 1
- FPL = 159%
- Patient has Private Insurance

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Nominal Fee – Case Study 2

- Completes HIV-related Medical appointment
- Insurance requires Co-Pay of $50
- Patient is charged nominal fee = $10 (20%)
- Grant assists patient with remainder of the co-payment = $40 (80%)

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</table>
Nominal Fee – Case Study 3

• Person living with HIV
• Annualized income = $26,450
• Household Size of 2
• FPL = 165%
• Patient is assessed for insurance and does not currently have insurance options
Nominal Fee (Fixed Rate) – Case Study 3

• Completes HIV-related Medical appointment
• Full Charge of appoint is typically $150
• Patient is charged fixed rate nominal fee of $10

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Nominal Fee (Percentage) – Case Study 3

- Completes HIV-related Medical appointment
- Full Charge of medical appoint is $150
- Patient is charged a nominal fee based on percentage of charges $30

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The law limits the annual cumulative charges to an individual for HIV-related services based on FPL and gross annual income (income made before taxes and other deductions are taken out).
Each RWHAP Part C program must have a system in place to ensure that these annual caps on charges to patients are not exceeded.

Organization must track the patient’s income and charges imposed (cap on charges).

- The patient tracks charges imposed across programs.
Ryan White Legislation: Patient Cap on Charges

• According to legislation, patient caps on charges
  – Should be calculated and updated annually
  – Based on charges imposed, not on payments made
  – Applies to both insured and uninsured patients

• Caps on Charges should consider: insurance premiums, copayments and coinsurance (PCN 13-05, 13-06, 14-01)
Ryan White Legislation: Patient Cap on Charges

- FPL: ≤100%, Cap: 0%
- FPL: 101-200%, Cap: 5%
- FPL: 201-300%, Cap: 7%
- FPL: >300%, Cap: 10%
Nominal Fee - Case Study 1

- Person living with HIV
- Annualized income = $14,916
- Household Size of 1
- FPL = 125%
- Cap on Charges: **$745.80 (5%)**
- Patient has Medicare

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• Completes HIV-related medical appointment
• Patient responsibility after Medicare
  – Patient balance after Medicare = $51.25
  – Patient is charged nominal fee of $5
  – $5 is applied to patients cap on out of pocket charges of $745.80
Nominal Fee – Case Study 2

- Person living with HIV
- Annualized income = $18,576
- Household Size of 1
- FPL = 159%
- Cap on out of pocket charges - $928.80
- Patient has Private Insurance

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Nominal Fee – Case Study 2

- Completes HIV-related Medical appointment
- Insurance requires Co-Pay of $50
- Patient is charged nominal fee = $10 (20%)
- $10 is applied to patients cap on out of pocket charges on $928.80

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</table>
Nominal Fee – Case Study 3

• Person living with HIV
• Annualized income = $26,450
• Household Size of 2
• FPL = 165%
• Cap on out of pocket charges: $1,322.50
• Patient is assessed for insurance and does not currently have insurance options
Completes HIV-related Medical appointment

Full Charge of medical appoint is $150

Patient is charged a nominal fee based on percentage of charges $30

$30 is applied to patients cap on out of pocket charges on $1,322.50

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Completes HIV-related Medical appointment
Full Charge of appoint is typically $150
Patient is Charged fixed rate nominal fee of $10
$10 is applied to patients cap on out of pocket charges on $1,322.50

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<td>$10</td>
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</table>
Case Study 4 – Cap on Charges

• Newly diagnosed w/HIV
• Annualized income = $49,200
• Household Size of 2
• FPL = 307%
• Cap on charges = $4,920
• Patient is assessed for insurance – is available for Marketplace plan, but it is not open enrollment
Case Study 4 – Cap on Charges

• Patient Brings in bill from inpatient hospital stay due to PCP for $12,000

• Patient’s bill is applied to his cap on out of pocket charges, Patient meets cap.

• Patient is not charged for HIV-related outpatient medical care for the remainder of his enrollment year

• Patient is assessed and enrolled into an insurance plan during open enrollment
Program Income

- Tracking Program Income
- Enrollment & Eligibility
- Cap on Charges
- Sliding Fee/Discount Schedule
Program Income (PCN15-03)

• Program income is gross income earned by the recipient that is directly generated by a supported activity or earned as a result of the Federal award.

• Program income is typically generated by recipients and subrecipients as a result of charging for services and receiving payment from third-party reimbursement:
  – Insurance Companies
  – Patient payments on the sliding fee scale
It is the responsibility of the recipient to monitor and track program income earned.

Under the “additive” alternative, program income must be used for the purposes for which the award was made, and may only be used for allowable costs under the award.
Example Ryan White Enrollment Process

1. Patient Enrolls/Recertifies Annually
2. Patient is assessed and enrolled in Medicaid/Marketplace Insurance as eligible
3. Patients is assigned a level/cap on charges based on income and household information provided
4. Insurance information and sliding fee scale placement information is entered into billing system
5. All charges are billed to insurance initially (as applicable)
6. Sliding fee scale is applied on amount owed by patient after insurance has assisted
7. Patient is billed for amount owed based on the sliding fee scale
8. Grant assists with the difference between the amount owed and the patient’s responsibility
9. Patient charge is applied to patient cap on out of pocket charges
10. Program should check in with patient after 6 months of enrollment to ensure nothing (insurance eligibility/income) has changed.
11. Income from insurance/patient payment (if applicable) is applied to program income and reinvested back into the HIV program.
The Circle of Client Management

• All four steps in the process are required in order to be in compliance with legislative and programmatic guidelines
  – Enrollment & Eligibility
  – Sliding fee discount/schedule
  – Cap on charges
  – Tracking and Reinvesting Program Income

• Total compliance solidifies “who” is eligible and how Ryan White assists patients regardless of patient’s income and insurance status
After-Enrollment Letter to identify the patient's:
- Placement of the program’s sliding fee scale
- Cap on Out of Pocket Charges
- Type of Bills/Charges that apply to the Cap on Charges
- 6-month Recertification Date (required information)
- Annual Enrollment Date (required Information)
Patient Education Tools

Enrollment Verification Letter

Date: ____________________

Dear: ____________________

Your application for the Ryan White Grant Program has been completed.

Your enrollment is effective: ____________________

Your sliding fee scale level* is: ______

Your out of pocket Responsibility is: ______________

Your cap* on charges is: $_______

Charges that apply to your cap: Insurance Premiums, Co-Payments, Deductibles for medical care and medications, as well as nominal fees charged for services. Charges can occur on-site or through other medical service providers.

IF YOU RECEIVE A BILL........

If you receive a bill, contact one of the benefit managers as soon as possible.

Ryan White Benefit Manager 1 contact info:

Last Name, First Name
Email: benefitsmanager1@email.com
Phone: (123) 456-7891 Fax: (789) 123-4567
Mail: Enter Mailing Address Here Clinic

Ryan White Benefit Manager 2 contact info:

Last Name, First Name (se habla español)
Email: benefitsmanager2@email.com
Phone: (123) 465-7819 Fax: (798) 321-4567
Mail: Enter Mailing Address Here Clinic
Patient Education Tools

- Business Reply Envelopes to Mail in Bills/Receipts to apply to cap
- Worksheet to assist patient in tracking cap

**Patient Name:** ___________________________  **MRN:** ___________________________

**Sliding Fee Scale:** ___________________________  **Cap on Out of Pocket Charges:**

This Cap on Charges is effective for one year for the following dates:

_________________________ to ___________________________

Eligible charges for the Cap on Out Of Pocket Charges include: insurance premiums, co-payments, and deductibles; charges as a result of an ER visit or hospitalization; outpatient medical care charges - laboratory, radiology, diagnostic testing, and physician charges; as well as pharmacy and medication charges and copays.

**Cap on Charges Tracking Sheet**

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Provider</th>
<th>Brief Medical Description</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
Case Study 5 – Enrollment Process

- Person living with HIV
- Annualized income = $5,732
- Household size of 4
- Patient is uninsured
Case Study 5 – Scenario 1

Patient is below the FPL patient and should not be charged for outpatient HIV related medical care. The patient’s cap on charges is 0%

Patient is not eligible for Medicaid or Federal/State Marketplace plan

Patient receives HIV medical care without being assessed fees. Ryan White assists patient with HIV-related outpatient care

Patient is reassessed at 6 months for any changes in insurance/income.
Case Study 5 – Scenario 2

Patient is below the FPL patient and should not be charged for outpatient HIV related medical care. The patient’s cap charges is 0%

Patient lives in Medicaid Expansion State. Patient is eligible and enrolled in Medicaid

Patient does not live in Medicaid Expansion State. Patient is assessed and enrolled in state/federal Marketplace plan

Patient receives HIV medical care without being assessed fees. Grantee bills Medicaid/insurance company for billable services. Ryan White funds are used to assist patient with co-pays/co-insurance.

Grantee tracks income received from Medicaid/Insurance and invests it back into the HIV program
Case Study 6 – Enrollment Process

- Person living with HIV
- Annualized income = $80,000
- Household Size of 1
- FPL = 673%
- Cap on charges = $8,000
- Patient has private insurance
Case Study 6 – Enrollment Process

- Patient Has Co-Pays of $40 for medical visits
- Is responsible for 100% of co-pays
- Patient pays a cumulative out of pocket $500 for year (does not meet cap)
- Insurance payments are reinvested back into the HIV program
• Even though Patient E, for example, is responsible for 100% of co-pays, he/she will never be turned away from services because of inability to pay.

• The clinic could work out a payment plan so that Patient E could pay over time

• The clinic could wave copays for Patient E
Fiscal Health Technical Assistance

• *Fiscal Health: Systems to Sustainability* program helps ensure the fiscal sustainability of Ryan White funded recipients
  – Regional Trainings
  – Individualized Technical Assistance
  – Online Learning
This program is sponsored by HRSA/HAB and administered by HealthHIV.