

Practical Strategies for Addressing Federal and State Fiscal Requirements

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In this session we will discuss

- ▶ **Federal and state fiscal requirements**
- ▶ **Fiscal compliance assessment**
- ▶ **Implementing payer of last (PLR) resort policies**
- ▶ **Applying Federal Poverty Level (FPL) guidelines to assess sliding fees**
- ▶ **Financial sustainability**

Federal and State Fiscal Requirements



Statutory Requirements

- ▶ Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009)
- ▶ First enacted in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act
- ▶ Amended and reauthorized in 1996, 2000, 2006, and 2009
- ▶ Fiscal requirements in place and retained throughout amended versions of the statute

Fiscal Compliance Assessment



Newly Published Standards

- ▶ Issued on April 2011 by the HIV/AIDS Bureau (HAB) Division of Service Systems and are effective immediately
- ▶ Universal, Fiscal, and Program Monitoring Standards for Part A and Part B grantees:
<http://hab.hrsa.gov/manageyourgrant/granteebasics.html>

HAB Monitoring Standards Format

- ▶ **Standards are defined**
- ▶ **Performance measures and methods** for determining whether the standard is being met
 - Actions to take and data to collect and analyze
 - Most grantees will use these recommended approaches, but grantees may identify alternative, but equally sound, ways to assess compliance with the standard
- ▶ **Grantee responsibility** for meeting each standard
 - Suggested actions and data requirements for the grantee

HAB Monitoring Standards

- ▶ **Provider/subgrantee responsibility** for meeting the standard
 - Suggested actions the provider/subgrantee should be expected to take and data to be collected and maintained
 - Grantees and providers/subgrantees must implement some or all of these actions to ensure that the standard is being met
 - However, grantees have flexibility in deciding which of the recommended methods to use and what specific systems and actions to require from providers/subgrantees
- ▶ **Citations** provide the source for each standard
 - Legislation, federal regulations, federal or HAB policy, guidance are provided so users are able to find and review the source document that specifies the requirement

Demonstrate Compliance With Monitoring Standards

- ▶ Each standard lists the requirements need to ensure compliance
- ▶ Establish written tools, protocols, policies and procedures for conducting monitoring visits
 - Procedures should describe the use of tools, protocols, and methodologies during the site visit; a report should be on file for every visit; and if needed, a corrective action plan should also be on file
- ▶ Keep these documents available for the HAB Project Officer or HAB site visit team to review to demonstrate compliance with subgrantee monitoring requirements

Fiscal Accountability

- ▶ Proper stewardship of all grant funds including compliance with programmatic requirements
- ▶ Grantee accountability for the expenditure of funds it shares with lead agencies (usually health departments), providers, and/or consortia
- ▶ Business management systems that meet the requirements of the OMB code of federal regulations, programmatic expectations outlined in the grantee assurances and the Notice of Grant Award (NGA)
- ▶ activities that are supported under the Ryan White Program as outlined by OMB, Code of Federal Regulations, HHS Grant Policy Statement (Terms and Conditions), Program Assurances, and NGA

Monitoring

- ▶ Any provider or individual receiving federal funding required to monitor for compliance with federal requirements and programmatic expectations
- ▶ Monitoring activities expected to include annual site visits of all providers or subgrantees
 - The Code of Federal Regulations states that the HHS awarding agency will prescribe the frequency of monitoring activities
- ▶ Performance of fiscal monitoring activities to ensure that Ryan White Program funding being used for approved purposes
- ▶ Corrective actions taken when provider outcomes do not meet program objectives and grantee expectations, which may include: improved oversight, redistribution of funds, a "corrective action" letter, sponsored TA

Eligibility Determination/ Screening

- Screening and reassessment of clients to determine eligibility as specified by the EMA, TGA, state, or ADAP
 - Screen clients to determine eligibility for Ryan White Program services within a predetermined timeframe
- Reassessment of clients every six months to determine continued eligibility
- Eligibility policies that do not deem a veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits

Part B Fiscal Accountability

- ▶ For grantees with fiduciary intermediaries or administrative agents (AAs):
 - ▶ Adherence to 15% limit on proportion of federal funds spent on grant administration and planning and evaluation
- ▶ Use of grantee administrative funds only for allowable expenditures
- ▶ Aggregated subgrantee administrative expenses total no more than 10% of Part B service dollars
- ▶ Appropriate subgrantee assignment of Part B administrative expenses, with administrative costs (as specified in the standard)

Part B Fiscal Accountability

- ▶ Total clinical quality management (QM) costs that do not exceed 5% of the annual Part B grant or \$3 million (whichever is less)
- ▶ Expenditure of no less than 75% of service dollars on core medical-related services, unless a waiver has been obtained from HAB
- ▶ Total expenditures for support services limited to no more than 25% of service dollars
- ▶ Adherence to the 5% to 10% limit on the use of ADAP funds for access, adherence, and monitoring services

Part B Imposition and Assessment of Client Charges

- ▶ Unless waived, ensure grantee and subgrantee policies and procedures that specify charges to clients for services, which may include a documented decision to impose a nominal charge
- ▶ No charges imposed on clients with incomes < 100% of the Federal Poverty Level (FPL)
- ▶ Charges to clients with incomes > 100% of FPL on a discounted fee schedule and a sliding fee scale, with a cap on total annual charges for Ryan White Program-funded services (including ADAP) based on the % of client's annual income
 - ▶ 5% for clients with incomes 100% to 200% of FPL
 - ▶ 7% for clients with incomes 200% to 300% of FPL
 - ▶ 10% for clients with incomes > 300% of FPL

Part B Fiscal Accountability: Other Topics

- ▶ Unallowable costs
- ▶ Income from fees for services performed
- ▶ Financial management
- ▶ Property standards
- ▶ Cost principals
- ▶ Auditing requirements
- ▶ Matching or cost-sharing funds
- ▶ Maintenance of effort
- ▶ Fiscal procedures
- ▶ Unobligated balances

Implementing HAB Payer of Last Resort Policies



Ryan White Program PLR Policies

- The Ryan White Program is the PLR
- Grantees and their contractors or subgrantees must ensure that clients meet eligibility criteria for Ryan White Program-funded services
 - Including ADAP, Health Insurance Continuation Program, Part A AIDS Pharmacy Assistance Programs (APAs), and direct services
- Grantees and their providers must ensure that alternate payment sources are pursued *before* providing Ryan White Program-funded services
- Grantees must establish and monitor procedures to ensure that their subgrantees verify and document client eligibility

Ryan White Program PLR Policies

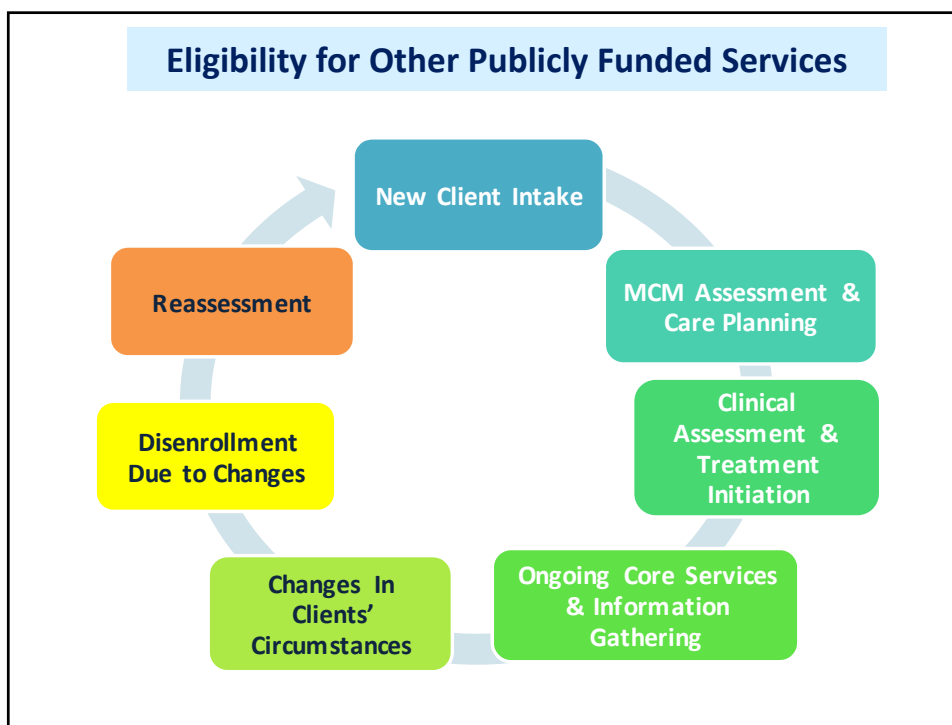
- ▶ Direct service grantees and subgrantees must document that their clients are screened for and enrolled in eligible programs and their benefits are coordinated after enrollment
 - These programs include Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), commercial health insurance, and State health insurance programs
 - Other programs include public housing, drug or mental health treatment, or Supplemental Nutrition Assistance Program (SNAP) (i.e., Food Stamps)
 - Income assistance, including disability income and Temporary Assistance to Needy Families (TANF)

Ryan White Program PLR Policies

- Ryan White Program funds may be used for HIV+ individuals with health insurance benefits
 - To cover specific clinical services or medications not covered in the benefits package (e.g., case management, behavioral health, oral health, or vision care)
 - When the individual's annual or lifetime benefits are capped by their insurer and additional services are required as documented by a medical provider (e.g., nursing home visits are capped, and the client needs additional home visits)
- Ryan White Program funds may be used to purchase premiums, deductibles, and co-payments if the client otherwise meets the Program's eligibility requirements
- **These and other HAB requirements are subject to audit and penalty**

Eligibility for Other Publicly Funded Services

- ▶ Under the Ryan White Program PLR policy, if a client is eligible for services through other publicly funded services they should be referred to those services *before* Ryan White Program-funded services are provided
- ▶ Examples include
 - Substance abuse treatment services
 - Mental health services
 - Food/pantry services, such as through SNAP
 - Transportation
 - Utility assistance



Monitoring PLR Activities

- ▶ ARIES and other client-level data systems can be used to conduct PLR monitoring
 - ▶ Analysis of household size and household income data may identify clients whose FPL needs additional documentation
 - ▶ Check insurer, household income, and client age are suggestion of health insurance coverage
 - ▶ Client age and number of OAMC visits are suggestive that the client may be disabled
- ▶ Chart audits with statistically accurate sample sizes, using standardized audit tools and trained auditors

Common Errors In Assessing Health Insurance Eligibility and Enrollment

- ▶ Assumptions that clients are uninsured
- ▶ Missed paystub notations regarding health insurance deductions
- ▶ Failure to ask the client if his/her spouse is insured and family benefits are available, and if the client is insured
- ▶ Missed health insurance cards in health or MCM records
- ▶ Failure to query employers about whether they offer health insurance
- ▶ Lack of communication among providers' staff about self-reports by clients that they are insured
 - ▶ Not routinely reviewing the health record of clients
- ▶ Insufficient understanding of SSA disability processes

Common Errors In Assessing Health Insurance Eligibility and Enrollment

- ▶ Lack of understanding about the association between SSI, SSDI, and TANF enrollment and Medicaid and Medicare benefits
 - ◀ Lack of understanding about the meaning of SSA award letters or Third Party Queries (TPQYs)
- ▶ Inadequate understanding about the availability of health insurance pools, tax district hospital benefits, and new “health care reform” insurance products
- ▶ Insufficient understanding of benefits available through the VA or military health system
- ▶ “Winking” about knowledge that the client can be insured but declines insurance coverage because the premiums, co-pays, or deductibles are too expensive

Ways to Increase PLR Capacity

- ▶ Standardization of client intake and assessment forms to guide accurate collection of information needed to determine eligibility for the Ryan White Program, as well as disability and income assistance programs and health insurance benefits
- ▶ Training and careful supervision of medical case managers
 - ◀ Chart monitoring
- ▶ Centralized eligibility determination processes
- ▶ Client education and resources
 - ◀ Standardized “dear employer” letters
- ▶ Internal audits, using a continuous quality improvement model
- ▶ Routine and careful monitoring by AAs
 - ◀ Training of monitors is critical

Assessing Part B FPL and Sliding Fee Scale Payments

PERCENT OF POVERTY GUIDELINES					
Family Size	100%	150%	200%	300%	400%
1	\$10,890	\$16,335	\$21,780	\$32,670	\$43,560
2	\$14,710	\$22,065	\$29,420	\$44,130	\$58,840
3	\$18,530	\$27,795	\$36,620	\$54,930	\$73,240
4	\$22,350	\$33,525	\$44,100	\$66,150	\$88,200
5	\$26,170	\$39,255	\$51,580	\$77,370	\$103,160
6	\$29,990	\$44,985	\$59,060	\$88,590	\$118,120
7	\$33,810	\$50,715	\$66,540	\$99,810	\$133,080
8	\$37,630	\$56,445	\$74,020	\$111,030	\$148,040

For family units of more than 8 members, add \$3,740 for each additional member.

Adapted from:

<https://www.cms.gov/MedicaidEligibility/downloads/POV10Combo.pdf>

TX DSHS: A household composed of 2 or more related persons or a household relationship based on responsibility for the care and well-being of others. A person who is not a relative by blood or marriage can be considered a family member if they are important to the care or well-being of a person with HIV. This does not include a live-in aide who is compensated to provide care.

Texas Part B Sliding Fee Scale Policy

- ▶ OAMC clients must be charged a fee
- ▶ OAMC providers may determine a fee for client without a third party payer through use of a sliding scale, or flat fee system
- ▶ The fee charged to clients with a billable third party payer will be determined by the third party payer
- ▶ Determine annual gross individual or family income for each client with no billable third party payer
- ▶ Assessment annually, or when client circumstances change
- ▶ Out-of-pocket expenses can include OTC drugs prescribed by a doctor; co-payments and other non-reimbursed medical costs for family members included in the financial eligibility assessment

Texas Part B Sliding Fee Scale Policy

- ▶ Contractors should create a tracking mechanism to ensure individual client charges do not exceed the maximum allowable annual charges
- ▶ Implement either sliding scale or flat fee system, using this chart for annual maximum allowable out-of-pocket expenses for the client
- ▶ Flat fees can be used to charge clients without a billable third party payer, up to a maximum based on individual or family annual gross income

Individual/Family Annual Gross Income	Total Allowable Annual Charges
Equal to or below FPL	No charges permitted
101 to 200 percent of FPL	5% or less of gross income
201 to 300% of FPL	7% or less of gross income
More than 300% of FPL	10% or less of gross income

Texas Part B Sliding Fee Scale Policy

- ▶ *Service providers must make a reasonable attempt to collect monies, however, services must be provided without regard to the ability of the individual to pay*
- ▶ Monies owed but not received from the client are not considered uncollected debt
- ▶ Agencies should not track these amounts, with any monies received is considered program income for that month regardless of when services when provided

Common Errors Made in Calculating Household Size and Income

- ▶ Inaccurate identification of household members, with fewer members identified than actually reside in the household
- ▶ Inaccurate identification of household income
 - Focusing only on the client, rather than assessing income of all household members
 - Identifying some but not all income
 - Inaccurate assessment of paystubs, SSA award letters, or other income documents
 - Using “self-generated” income documents (e.g., IRS forms)
 - Assessing “zero income” without exploring how the household supports itself
- ▶ These errors also contribute to inaccurate assessment of health insurance enrollment
- ▶ A Summary Earnings Query (SEQY) are requested from the SSA when earnings are unclear or questionable

Assessing Zero Income

- ▶ How does the applicant support him/herself without income or employment?
- ▶ How are food, clothing, shelter, and utilities being managed?
- ▶ How long has the applicant been unemployed?
- ▶ What is the applicant’s previous work experience?
- ▶ What are the applicant’s educational qualifications?
- ▶ Is the applicant underemployed? Could the applicant find better employment? Is the applicant currently looking for employment?
- ▶ Is the applicant receiving Unemployment Compensation?
- ▶ What is the reason for unemployment (medical, voluntary)? If medical, what is the status of disability/SSI determination? If voluntary, has PLR been discussed”?
- ▶ What efforts have been made to find a job?

Fiscal Sustainability



Why diversify funding streams?

- ▶ HIV programs rely heavily on Ryan White Program funds
 - ▶ Those funds have not kept pace with growth in the number of new and ongoing clients
- ▶ Other funding streams have dried up or becoming harder to get or keep and competition is fierce
- ▶ Health insurers do not cover costs, are narrowing benefits, or shifting costs to patients
- ▶ University, hospital, and public health systems are less likely to support the administrative and other costs of HIV programs due to financial destabilization
- ▶ HAB and other funders' administrative caps do not cover the cost of doing business

Why diversify?

- ▶ Clients' needs are growing in complexity, with increasing rates of unstable housing, mental illness, and addiction that require different or expanded funds
- ▶ Doing more for less may work for Target but not for your program
- ▶ Organizational survival



What is the goal of sustaining funding?

- ▶ Strategically harnessing HIV *and other funds* to meet the needs of HIV+ clients
- ▶ Ensuring that your clients have accessible, available, affordable, acceptable, and culturally component HIV care that is high quality
- ▶ Sustaining an efficient and effective HIV system of care
- ▶ Sustaining your program's mission through fiscal solvency

What are the keys to fiscal sustainability?

- ▶ Diversified funding streams, not just multiple “Parts” of the Ryan White Program
- ▶ Multiple products, populations, service areas, and site locations
- ▶ Creative, experienced managers in place
- ▶ Retention of key front line professional and support staff
- ▶ Long-term planning: for the best and worst of times
- ▶ Creative managers and board members

What are the characteristics of fiscally solvent HIV programs?

- ▶ Short *and* long-term vision
- ▶ Plan for the best and worst of times
- ▶ Multiple funding streams, products, service areas, and overlapping funding streams
- ▶ Creative, experienced managers in place
- ▶ Retention of key front line professional and support staff
- ▶ Know how much it costs to produce their services
- ▶ Have capital reserves in place
- ▶ Optimize resources from external sources
- ▶ Savvy advocates for the *greater* good
- ▶ Take advise from experts
- ▶ Play well in the sand box with others



Assessing Funding Sustainability

- ▶ Including donations and health insurers, how many funders support your HIV program?
- ▶ Is this number more or less than two years ago?
- ▶ Do any of these funders pay for services unrelated to HIV?
- ▶ How many “Parts” of the Ryan White Program fund your program?
- ▶ For how many RWHAP service categories is your program funded? How many of these categories are “core” services? How many are “non-core” services?
- ▶ For how many “products” does your program receive funding?
- ▶ In how many sites does your program offer your services? Do you co-locate with other programs?

Part A and B Grantee and AAs Quiz: True or False

- ▶ In the past 12 months, we have assessed:
 - ▶ The sources and amount of funds supporting HIV care in our jurisdiction
 - ▶ The funding diversity of our subgrantees
 - ▶ The extent to which our subgrantees have sought funds from other sources
- ▶ We look for new funding sources at least monthly
- ▶ We routinely disseminate information to our providers about funding opportunities besides RWHAP
- ▶ We assist our providers to expand their capacity to seek successfully other funds
- ▶ We assist our providers to enroll in public and commercial health insurance

Part A and B Grantee Pop Quiz: True or False

- ▶ We only look for funds from government sources
- ▶ In the past two years, we have successfully applied for HIV funds from sources other than HAB
- ▶ We have a contingency plan if one or more providers close
- ▶ We are really nervous now

Assessing Funding Sustainability

- ▶ Including health insurers, how many non-Ryan White Program funders support your program?
- ▶ Does your program participate in third party health insurance?
- ▶ For core service providers, how many health insurers do you participate? For what services? How many of your licensed personnel are credentialed to provide services to network members?
- ▶ What proportion of your grants or contracts are for greater than 12 months?
- ▶ What is the proportionate distribution of your program revenue by funders?
- ▶ If you lost funding from any of your funders TODAY, what would be the impact?

Provider Pop Quiz: True or False

- ▶ Our program successfully applied for funds in the last year from at least one new funder
- ▶ Our program has estimated the cost of providing each type of service we provide
- ▶ Our program's annual revenue is greater than our expenditures
- ▶ Our program has enough capital reserve to sustain our costs for six months
- ▶ For CBOs: We have at least one board member that gives us helpful advise about diversifying our funding

Provider Pop Quiz: True or False

- ▶ For HIV programs in larger organizations:
 - ▶ Our "parent organization" has provided our HIV program with expert advise about diversifying our funding
 - ▶ In the last twelve months, our "parent organization" has reduced administrative funds or other resources for our HIV program
 - ▶ In the last twelve months, our parent organization has informed us that our HIV program must increase revenue
- ▶ We look for new funding sources at least monthly
- ▶ Our program has considered laying off employees due to insufficient funds
- ▶ Our program has a line of credit
- ▶ Our program has drawn on our line of credit in the last 12 months
- ▶ I am now really nervous

What can HIV programs do to diversity their funding?

- ▶ Assess your program's funding "portfolio," your vulnerabilities, and your strengths
- ▶ Use your program's data effectively
- ▶ Assess your program's capacity to raise funds through grants, contracts, and other mechanisms
 - ◀ Can you successfully compete alone or should you partner?
 - ◀ Should you lead efforts to apply for funds or partner with another agency with more capacity?
- ▶ Assess your program's capacity to reengineer your services or target populations

What can HIV programs do?

- ▶ Develop a marketing plan
- ▶ Advertise their services
 - ◀ Accessible websites and other creative strategies
- ▶ Develop effective, targeted fund raising skills
- ▶ Work with your board or parent organization to ensure their buy-in
- ▶ Avoid competition for the same funds with other agencies in your community
 - ◀ Joint proposals are much more successful!

What can HIV programs do?

- ▶ Expand your portfolio
 - ▶ Identify gaps in service availability and accessibility
 - ▶ Add new services for your current target population, new targeted populations, and/or service areas
 - ▶ Increase revenue by contracting with other payers that serve your target populations and service areas
 - ▶ Increase revenue by contracting with other funders that serve your target populations and service areas

How can we be more competitive and maximize our revenue?

- ▶ Rapidly engage and retain clients in care
- ▶ Cost of services are known and managed to reduce unnecessary expenses
- ▶ Discontinue providing services for which revenue does not cover costs
- ▶ Identified clients that are insured or can be insured so increase revenue
- ▶ Forge “virtual” or real partnerships with other organizations
- ▶ Third party insurance billing is maximized to the extent that is legal
- ▶ Improvements in efficiency have been identified and addressed Increase volume by enhancing productivity
- ▶ Quality of services are assessed so you can demonstrate your value to funders
- ▶ Capacity of personnel is evaluated to ensure that they are performing optimally
- ▶ High quality staff are retained to avoid gaps in service and recruitment costs

What grantees and AAs can do?

- ▶ Let other funders in your jurisdiction know that the Ryan White Program does not cover the need for all HIV-related services
- ▶ Plan for Ryan White Program funding allocations, as well as develop a true system of HIV care
- ▶ Foster development of an efficient, effective integrated HIV care network to ensure fundability by other funders
- ▶ Encourage collaboration, not competition
- ▶ For funding applications, document the
 - HIV epidemic, gaps in services, shortfalls in funds, and other measures of need for other fund sources
 - Capacity, volume, cost, and quality of HIV providers

What grantees and AAs can do?

- ▶ Help to foster a collaborative environment to decrease duplicated effort in seeking funds
- ▶ Acknowledge and capitalize on the strengths of partner agencies
- ▶ Help to broker “power relationships” between collaborating HIV programs
- ▶ Alert providers on a timely basis about the availability of funds
- ▶ Help to coordinate multi-agency fund raising, including grant and contract proposals
- ▶ Request TA and capacity building

Questions And Discussion



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