

## Show me the Program Income

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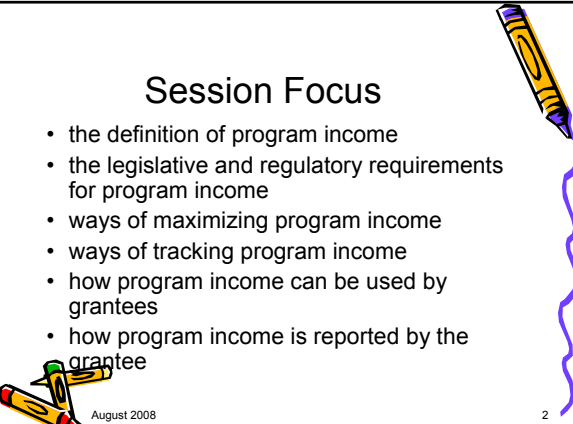
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## Session Focus

- the definition of program income
- the legislative and regulatory requirements for program income
- ways of maximizing program income
- ways of tracking program income
- how program income can be used by grantees
- how program income is reported by the grantee

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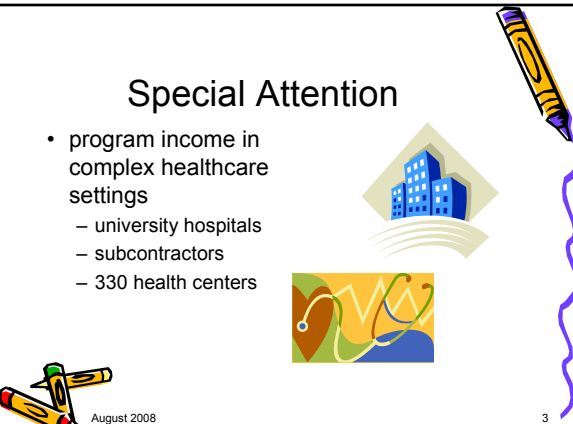
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## Special Attention

- program income in complex healthcare settings
  - university hospitals
  - subcontractors
  - 330 health centers



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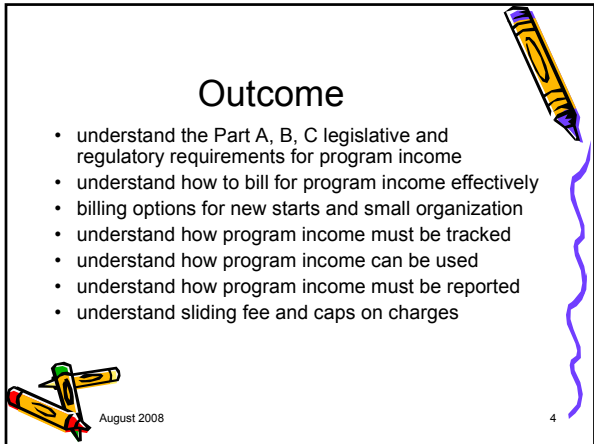
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## Outcome

- understand the Part A, B, C legislative and regulatory requirements for program income
- understand how to bill for program income effectively
- billing options for new starts and small organization
- understand how program income must be tracked
- understand how program income can be used
- understand how program income must be reported
- understand sliding fee and caps on charges



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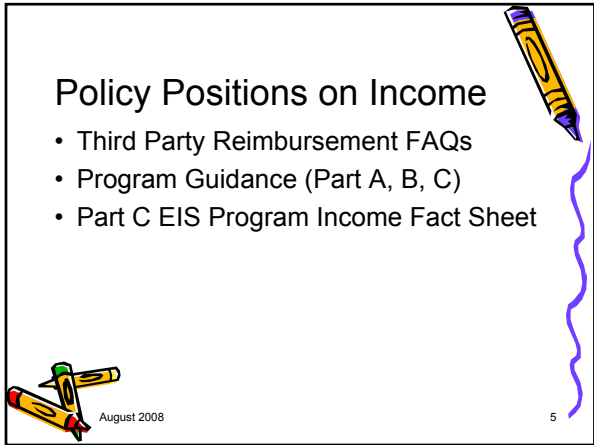
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## Policy Positions on Income

- Third Party Reimbursement FAQs
- Program Guidance (Part A, B, C)
- Part C EIS Program Income Fact Sheet



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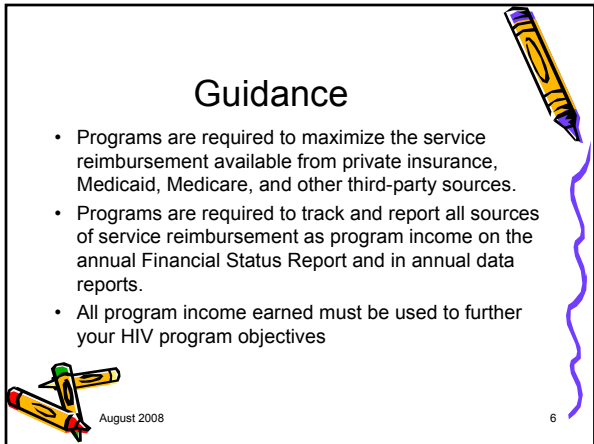
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## Guidance

- Programs are required to maximize the service reimbursement available from private insurance, Medicaid, Medicare, and other third-party sources.
- Programs are required to track and report all sources of service reimbursement as program income on the annual Financial Status Report and in annual data reports.
- All program income earned must be used to further your HIV program objectives



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## What is Program Income?

- Program income is any income that is generated for a grantee or subcontractor by the grant or earned as a result of the grant.
- This includes charges to beneficiaries under the sliding scale, as well as reimbursements from Medicaid, Medicare, and private insurance for services provided.

Grants Policy Directive 1.02: 45 CFR 92.25

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## Maximizing Income

- Eligibility
  - Identify sources of third party revenue for each clients
  - Refer clients for health insurance eligibility determination
  - Electronic billing verification
- Contracting Billing systems
  - Negotiate the best reimbursement rates possible
- Billing all allowable services
  - Provider generated-billable visits

Third Party Reimbursement FAQs

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## Maximizing Income

- Importance of fee schedule
- Cost based reimbursement
- Prospective Payment System
- Estimating income
  - Average charge per visit-Medicaid/Others
  - Collection rage
- Managed Care
  - Capitation

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## Maximizing Income for new starts and small grantees

- Choose a practice management system
- Development of a billing infrastructure
- Outsourcing/subcontracting options



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## Maximizing Medicaid Income

- Grantees and their contractors are expected to vigorously pursue Medicaid enrollment for individuals likely eligible for Medicaid coverage
- Seek payment from Medicaid when they provide Medicaid covered services for Medicaid beneficiaries
- Back bill Medicaid for Care Act-funded services provided for all Medicaid eligible clients upon determination.



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## Tracking Data

- Utilization Data : Clinical and Fiscal
  - Visits
  - Hospitalizations
  - Labs (CD4 - Viral Loads)
- Prescriptions
- Cost Center Budgets



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## Payer of Last Resort

- Care Act grant funds cannot be used to make payments for any item or service if payment has been made, or can reasonably be expected to be made with respect to that item or service under any State compensation program, under any insurance policy, or under any Federal or State health benefits program; or by an entity that provides prepaid health care.



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## Screening & Reports

- New Patient Intake - captures patient income
- Group Patients by Poverty Level
- Generate monthly reports of patient charges
- Monitor YTD charges
- Flag patients who are near cap
- Stop charges when appropriate



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## Self-Pay & Sliding Fee Scales

- Patient Registration
- Accounts Payables
- Collections
- Caps – Part C
- No denial of service



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# U.S. Poverty Guidelines

- Published Annually in the Federal Register
- Health and Human Services Posts them on the Web



<http://aspe.hhs.gov/poverty/index.shtml#latest>



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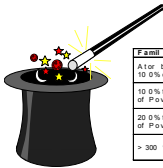
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# Sliding Fees & Caps

2008 HHS Poverty Guidelines			
Family Size	48 States & D.C.	Alaska	Hawaii
1	10,400	13,000	11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
Add for each additional person	3,600	4,500	4,140



Family Income	Max Charge
At or below 100% of Poverty	0
101% to 200% of Poverty	No more than 2% of gross annual income
201% to 300% of Poverty	No more than 7% of gross annual income
> 300%	No more than 10% of gross annual income



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# Sliding Fee Scale Sign

## Notice to Patients:

This health center serves all patients regardless of ability to pay. Discounts for essential services are offered depending on family size and income. You may apply for a discount at the front desk.



Source: Bureau of Primary Health Care

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## Fee For Service

- Medicaid Fee Schedules
  - Medical
  - Mental Health
  - Case Management
  - Pharmacy
  - Laboratory



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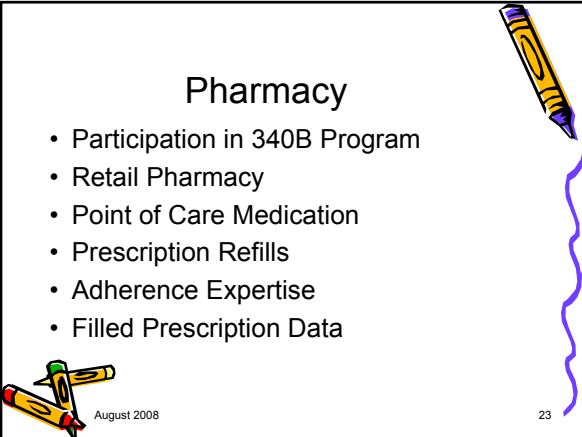
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## Pharmacy

- Participation in 340B Program
- Retail Pharmacy
- Point of Care Medication
- Prescription Refills
- Adherence Expertise
- Filled Prescription Data



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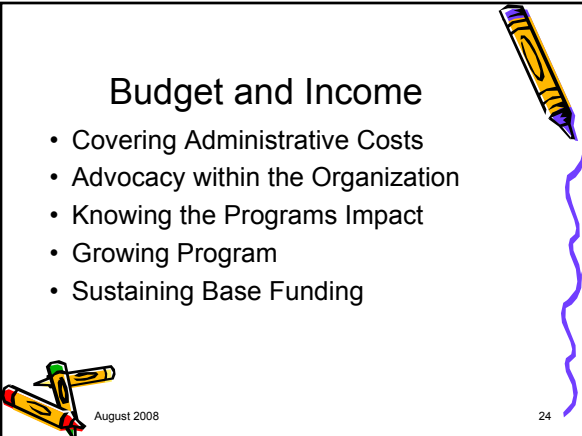
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## Budget and Income

- Covering Administrative Costs
- Advocacy within the Organization
- Knowing the Programs Impact
- Growing Program
- Sustaining Base Funding



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## No Fear of Income

- HRSA discourages grantees from reducing grant funding for sub-grantees or contractors that collect third party reimbursement revenues.
- Grantees are encouraged to work closely with and encourage and assist sub-grantees and contractors to effectively utilize their CARE Act funds and collect third party reimbursement, by maintaining the same level of CARE Act funding and using the funding to expand and/or enhance HIV/AIDS services to current eligible clients and/or identifying and enrolling into care new eligible clients in the sub-grantee or contractor service area(s).



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## TACT: Technical Assistance Cost Tool

- for use by clinics and individual providers who want to identify the costs of delivering health care services to patients living with HIV and AIDS.
- TACT reports provide cost analyses for internal clinic financial management for third-party reimbursement.
- will assist providers in contract negotiations with managed care organizations that offer the opportunity to participate in their provider network.
- providers will know the cost of the care they provide and can therefore determine the financial adequacy of payment rates in both a fee-for-service and managed-care context.



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<http://www.hrsa.gov/tact/>

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## TACT: Unit of Service: Total Cost of Service:

Institutional Care	Ambulatory Care	Other	Other
ICU/CCU	Routine Visit	Nutritional Counseling	Nutritional Counseling
Medical/Surgical	Comprehensive	Physical Therapy	Physical Therapy
OB	Obstetric / Pre-Natal	Occupational Therapy	Occupational Therapy
Newborn	OTN / Family Planning	Respiratory Therapy	Respiratory Therapy
Other Hospital Care	Other Primary Care	Speech Therapy	Speech Therapy
Mental Health	After Hours - Urgent	TB/ Direct Observed Therapy	TB/ Direct Observed Therapy
Substance Abuse	Weekend - Urgent/Routine	Massage Therapy	Massage Therapy
Other Behavioral Health	Other Urgent Care	Acupuncture	Acupuncture
Laboratory	Dental	Other Therapy	Other Therapy
Radiology	Gastrointestinal	Nursing Case Management	Nursing Case Management
Anesthesia	Dermatology	Other Case Management	Other Case Management
Other Hospital Ancillary	Diabetes / Endocrinology	Home Infusion	Home Infusion
Emergency Room	Hematology (Dialysis)	Other Home Health Care	Other Home Health Care
Outpatient Surgical	Oncology		
Outpatient Specialty Care	Cardiology	Ancillary Clinical	
Other Hospital Specialty	Ophthalmology	Laboratory	
SNF/Step Down	Podiatry	Radiology/X-ray/MRI	
Nursing Home	Urology	Other Ancillary Clinical	
Day Care Centers	Neurology		
Hospice	Other Specialty		
Other	Infectious Disease		



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## TACT: Summary Report

Aco Hospital Clinic Hospital Supported Clinic 1000 HIV Patients					
Service Category	Sub Category	Unit Name	PROVIDER Cost & Utilization Data		
			Actual Unit/100 Members	Average Cost per Service	Total Gross Cost % PMPM
<b>Institutional Care</b>					
Hospital Care	Hospital Care	Days	6,000.0	\$ 3,000.00	\$ 1,200.00
	Behavioral Health	Days	440.0	\$ 2,000.00	\$ 75.33
	Healthcare Services	Visits	250.0	\$ 1,000.00	\$ 15.67
<b>Other Institutional</b>					
	Homecare	Days	600.0	\$ 500.00	\$ 20.00
<b>TOTAL Institutional Care</b>					\$ 1,385.00
<b>Outpatient Care</b>					
Primary Care	Routine Visit	Visits	2,200.0	\$ 70.00	\$ 14.00
	Comprehensive	Visits	500.0	\$ 100.00	\$ 4.17
After Hours / Urgent	Weekend - Urgent/Routine	Visits	100.0	\$ 100.00	\$ 0.83
Specialty Care	Specialty Care	Visits	400.0	\$ 100.00	\$ 3.33
Infectious Disease	Infectious Disease	Visits	500.0	\$ 100.00	\$ 4.17
Other Professional	Nutritional Counseling	Visits	500.0	\$ 35.00	\$ 1.46
Case Management	Case Management	Hours	2,700.0	\$ 50.00	\$ 11.25
Behavioral Health	Substance Abuse	Visits	1,200.0	\$ 50.00	\$ 3.00
<b>TOTAL Outpatient Care</b>					\$ 44.27
<b>Additional Services</b>					
	Outreach	Visits	200.0	\$ 50.00	\$ 0.83
	Counseling & Testing	Hours	250.0	\$ 50.00	\$ 1.64
	Health Education - Prevention	Visits	250.0	\$ 30.00	\$ 0.83
	Transportation	Services	200.0	\$ 20.00	\$ 0.50
	Translation Services	Hours	80.0	\$ 100.00	\$ 0.42
<b>TOTAL Additional Services</b>					\$ 2.91
<b>PHARMACY</b>					
	NONE				
<b>GROSS MEDICAL COSTS</b>					\$ 1,410.32

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## Reporting Income

- Ryan White HIV Data Report
  - Whole Program Costs
- Financial Status Report
  - Required to Qualify for Supplemental Funding when available

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