THE EFFI BARRY TRAINING INSTITUTE

Fiscal Health Training

Washington, DC
Thursday, June 28, 2018

DC | HEALTH HealthHIV

Effi Barry HIV/AIDS Institute

The Effi Barry HIV/AIDS Institute, led by HealthHIV, provides:

- Capacity Building
- Technical Assistance
- Support

How?

- Through a series of group-level trainings, boot camps, community forums, and individual consultation.

This program is funded wholly, or in part, by the Government of the District of Columbia, department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA).

DC | HEALTH HealthHIV

Today's Objectives

- Describe Ryan White legislative and programmatic requirements
- Review recipient and subrecipient responsibilities related to Ryan White program activities
- Identify strategies for expanding service delivery and program sustainability

Agenda

Thursday, June 28, 2018	
9:00AM	Overview and Introductions
9:15AM	Understanding HRSA/HAB National Monitoring Standards
10:45AM	Break
11:00AM	Implementing a Schedule of Charges and Caps on Patient Charges
12:00PM	Lunch
1:00PM	Managing Program Income
2:30PM	Break
3:00PM	Reporting Time and Effort
4:00PM	Wrap-Up and Evaluation

DC | HEALTH HealthHIV

THE EFFI BARRY
HIV/AIDS INSTITUTE

Understanding and Implementing HRSA/HAB Fiscal Monitoring Standards and HHS Uniform Guidance

DC | HEALTH HealthHIV

Fiscal Monitoring Standards (FMS)

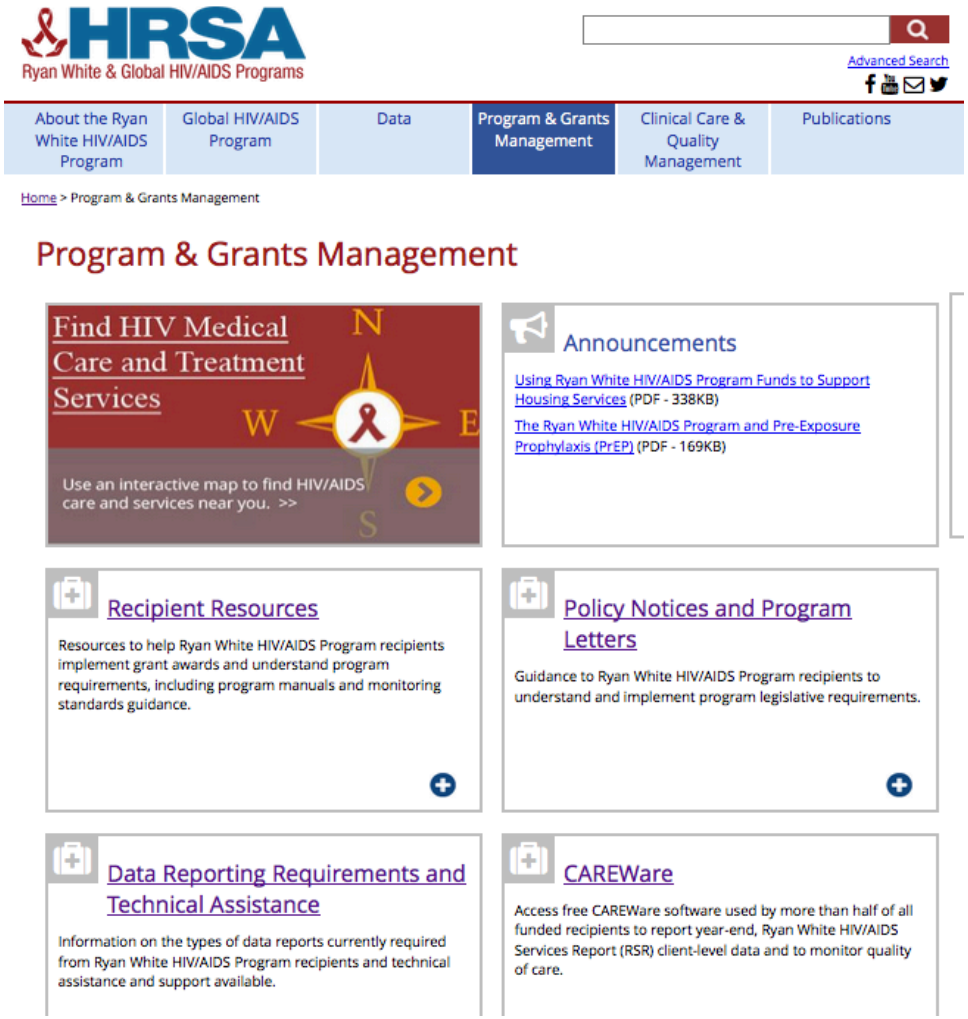
- Guidance for Ryan White recipients/ subrecipients on HRSA/HAB expectations for grants management
- Covers fiscal management and compliance topics
- Defines performance measure, recipient responsibility, and subrecipient responsibility

Fiscal Monitoring Standards (FMS)

Sections covered:

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

DC | HEALTH HealthHIV

HRSA Resources

Monitoring Standards Guidance

Below is monitoring standard guidance for Ryan White HIV/AIDS Program Parts A and B recipients.

- Fiscal Monitoring Standards: Part A (PDF - 658 KB) and Part B (PDF - 778 KB)
- Program Monitoring Standards: Part A (PDF - 508 KB) and Part B (PDF - 594 KB)
- Universal Monitoring Standards: Parts A and B (PDF - 434 KB)
- Frequently Asked Questions (FAQs) (PDF - 200 KB)

Ryan White HIV/AIDS Program Manuals and Reports

- Ryan White HIV/AIDS Program Part A Manual (PDF - 1.47 MB)
- Ryan White HIV/AIDS Program Part B Manual - Revised 2015 (PDF - 2.2 MB)
- Ryan White HIV/AIDS Program AIDS Drug Assistance Program (ADAP) Manual Revised 2016 (PDF - 577 KB)
- 2016 Annual Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual

Additional Recipient Resources

- Impact of Medicaid 1115 Waivers on the Ryan White HIV/AIDS Program - Case Studies Presentation (PDF - 429 KB)
- Impact of Medicaid 1115 Waivers on the Ryan White HIV/AIDS Program - Case Studies (PDF - 337 KB)
- Understanding and Monitoring Funding Streams in Ryan White HIV/AIDS Program Clinics: Survey Results Presentation (PDF - 376 KB)
- Understanding and Monitoring Funding Streams in Ryan White HIV/AIDS Program Clinics, Final Report Executive Summary (PDF - 423 KB)

Date Last Reviewed: October 2016

DC | HEALTH HealthHIV

Fiscal Monitoring Standards: Snapshots

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Section C: **Income from Fees for Services Performed**				
1. Use of Part A 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) and • Private insurance	• 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 subgrant agreement or through another mechanism that subgrantees maximize and monitor third party reimbursements • Requirement that subgrantees document in client records 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 and 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 2605(a)(6) Funding Opportunity Announcement
2. Ensure billing and collection from third	• Inclusion in subgrant agreements of language that	• Include provisions in subgrant agreements that	Establish and consistently implement:	PHS ACT 2605(a)(6)

FMS and 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%**
  - ADAP-specific regulations for Part B

Limits on Admin, Plan/Eval, & QI Costs

- PCN 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 (admin. 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 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

- More flexibility around administrative costs
- Some costs previously considered administrative can now 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 or it is still considered administrative

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 expenditures for support services
- HRSA defines support and core medical services
- Recipients may request a waiver 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 services are available within 30 days
  - Public process supports the waiver
  - Narrative explanation

Unallowable Costs

Ryan White funds cannot cover the costs of . . .

- 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 (continued)

Ryan White funds cannot cover the costs of . . .

- 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

- Recipients should maintain a list of allowable and unallowable costs
- Make this list available for subrecipients and include in communications (including 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
- Charges imposed on **and collected from** clients
- Savings generated from 340B Drug Pricing Program

Tracking and Reporting Program Income

- Recipients must report their program income in aggregate in the Federal Financial Report (program income **earned** in line I and **expended** in line n) 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.
- Exceptions for IHS and VA.

Source:
Part A: 42 U.S.C.A. § 300ff-15 (a)(6)
Part B: 42 U.S.C.A. § 300ff-27 (b)(7)(F)

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
100% - 200% of FPL	No more than 5% of Annual Income
200% - 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.

Client Charges

- Providers must publicly post their schedule of charges.
- If a provider charges any fees to any clients, they usually 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 your 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 you acquire 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.

Accounting and Audit Guidelines

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.

Accounting and Audit Guidelines

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

- Your Notice of Award (NoA) will disclose if you are 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 maintenance of 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 consistent, rational methodology.

Unobligated Balances

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

Rebates

- Applicable to Part B/ADAP
- Must be applied to the program, priority on ADAP
- Rebate funds must be expended prior to drawing down grant funds
- If this results in higher UOB, a recipient can reduce the UOB by the amount of obligated rebate funds
- Rebates are disclosed on the FFR (line 12) but are NOT shown as program income or part of unobligated balances

45 CFR 75 – Effective Dates

Applicable to all HAB grants and cooperative agreement issued on or after December 26, 2014

- New "Type 1" awards
- Competing Continuation "Type 2" awards
- Non-competing Continuations "Type 5" awards
- Supplements
- Carry over funds re-obligated after 12/26/14

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.

Uniform Guidance Goals

- Strengthen oversight over Federal funds to reduce risks of waste, fraud, and abuse
- Increase efficiency and effectiveness of Federal awards

45 CFR 75 – Vocabulary

Subrecipient vs Contractor

- Subrecipient carries out programmatic activities to meet the goals and objectives of the funded project
- Contractor provides goods and services within normal business operations for the benefit of the recipient (ancillary to the operation of the recipient)

Questions to Ask to Determine: Subrecipient vs. Contractor

Subrecipient	Contractor
Determines who is eligible to receive Ryan White assistance;	Provides the goods and services within normal business operations;
Has its performance measured in relation to whether program objectives were met;	Provides similar goods or services to many different purchasers;
Has responsibility for programmatic decision making;	Normally operates in a competitive environment;
Is responsible for adherence to applicable Ryan White program requirements specified in the award; and	Provides goods or services that are ancillary to the operation of Ryan White; and
In accordance with its agreement, uses funds to carry out Ryan White, as opposed to providing goods or services for the benefit of a pass-through entity	Is not subject to compliance requirements of Ryan White as a result of the agreement

Defining Subrecipients

Recipient: City X

Subrecipient: Hospital system in City X providing Early Intervention Services

Contractor: Waste management company that collects the hospital's biomedical waste

Contractor: Third-party billing company that processes medical billing

Difference: Subrecipient performs a role within a service category (core medical or support), while the contractor does not

Subrecipient Risk Assessment

Risk Assessment Framework

- Pre-award financial risk assessment
  - Financial stability
  - Single Audit
- Adequacy of management systems
- History of performance
- Capacity to meet award requirements

Conflict of Interest

Recipients and subrecipients must:

- Maintain written standards of conduct covering conflicts of interest and governing the actions of its employees engaged in the selection, award, and administration of contracts
- Maintain organizational conflict of interest records

Changes to Procurement

- Strong focus on conserving cost in the guidance.
- Entities are asked to conduct lease versus purchase alternatives, where appropriate, and to share or use surplus Federal property before purchasing new equipment.

Changes to Audit Requirements

- The threshold for Single Audits raised from $500,000 to $750,000
- Federal agencies are prohibited from granting an extension to the Single Audit deadline
- Threshold for questioned costs – raised from $10,000 to $25,000

Discussion & Questions

THE EFFI BARRY
HIV/AIDS INSTITUTE

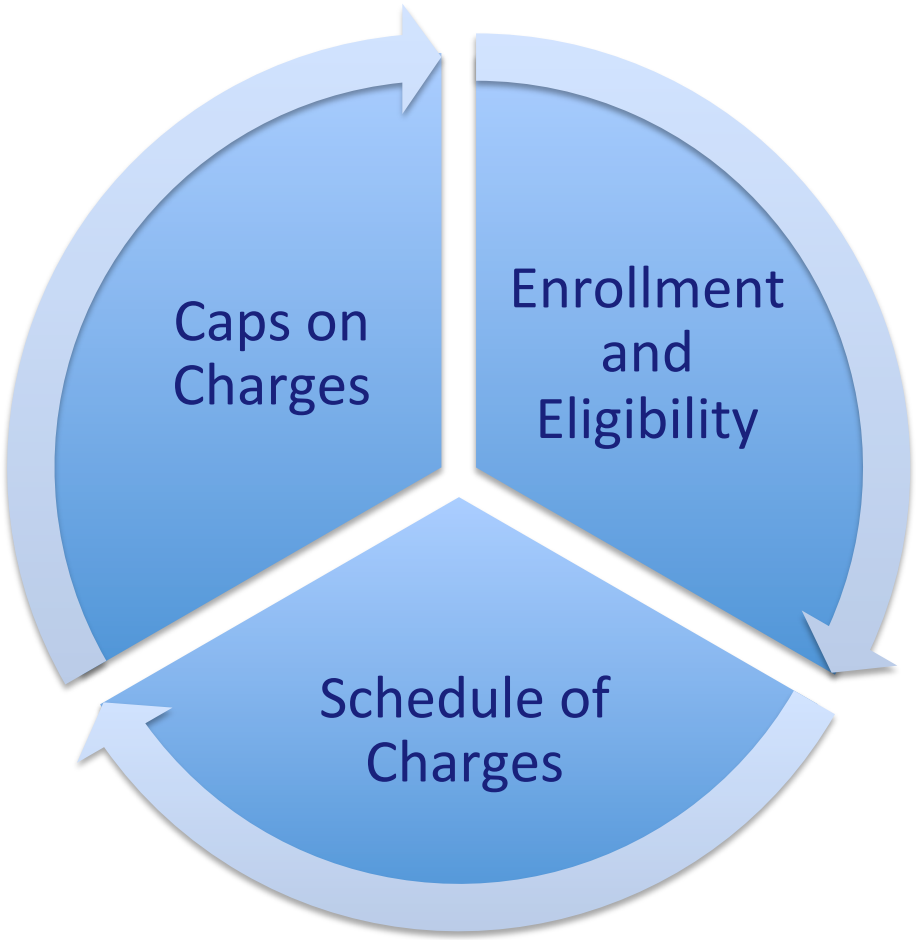
Implementing a Schedule of Charges & Caps on Charges

DC | HEALTH HealthHIV

Learning Objectives

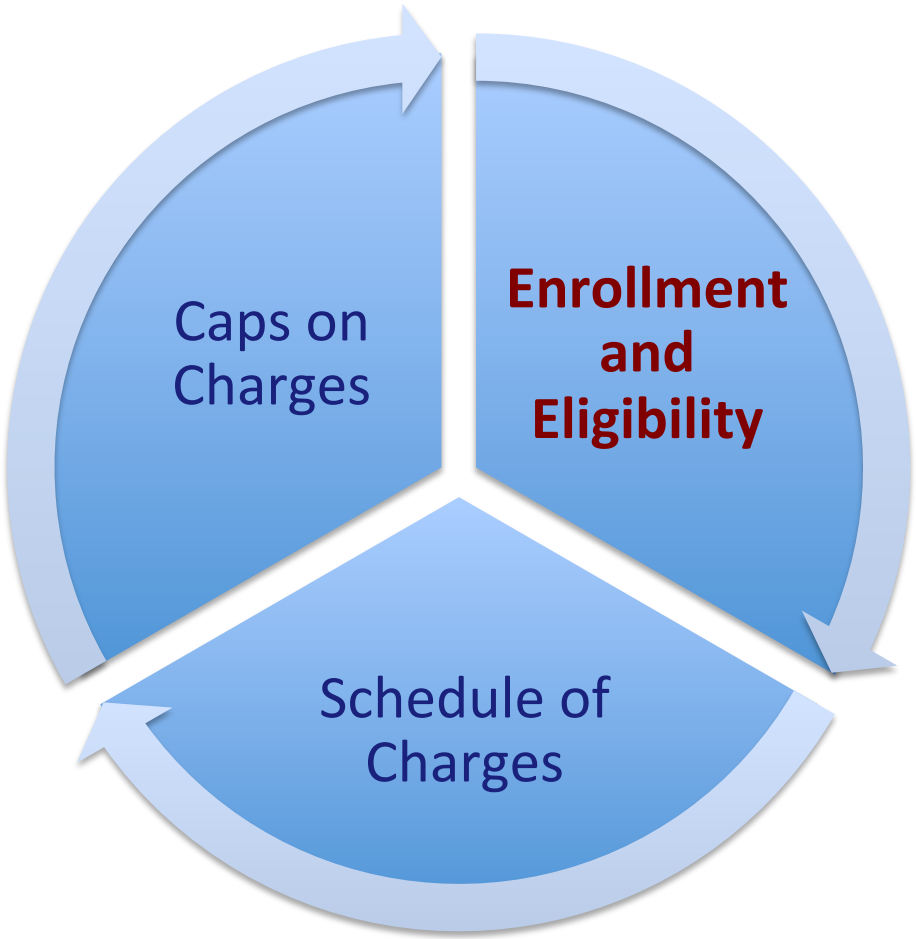
- Review legislative and HRSA/HAB requirements related to implementing schedule of charges and caps on charges policies
- Discuss components of a schedule of charges policy
- Discuss recipient and subrecipient responsibilities for implementing and documenting patient charges

The Circle of Assessing Client Charges



DC | HEALTH HealthHIV

Enrollment & Eligibility



DC | HEALTH HealthHIV

Ryan White Eligibility

Ryan White legislation requires that individuals receiving Ryan White services must:

- Have a diagnosis of HIV/AIDS and
- Be low-income as defined by the recipient
- Parts A & B Planning Bodies/Consortia may define eligibility more precisely (specified income cap) but may not broaden the definition (PCN 16-02)

HRSA/HAB Policy Clarification Notice 13-02

Income Calculations

Ryan White eligibility and schedule of charges both require proof of income; however

- Ryan White program eligibility is based on ***household*** income
- Schedule of charges is based in ***individual*** income

Enrollment & Eligibility

The enrollment and eligibility process facilitates the recipient's determination regarding imposition of charges for services

- Identifies the patient's placement on the schedule of charges
- Applies the pre-determined discount on charges
- Determines the patient's cap on out-of-pocket charges

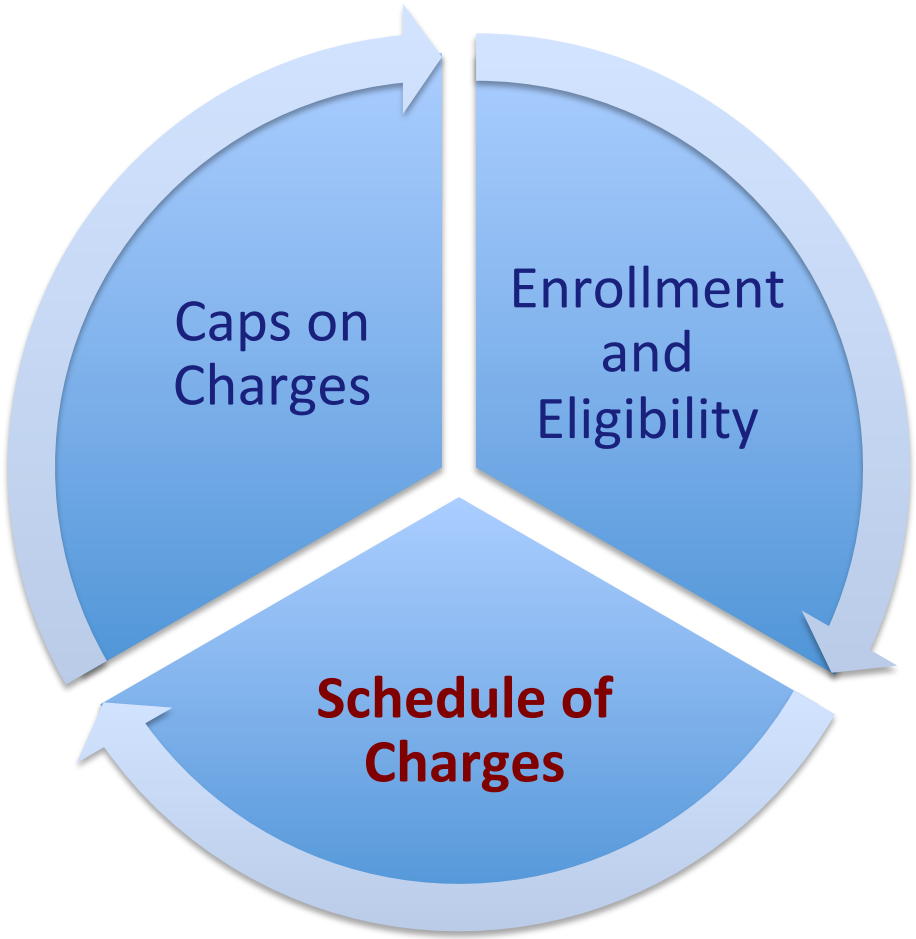
Example Ryan White Enrollment Process

1. Patient enrolls
2. Patient is assessed and enrolled in Medicaid/ Marketplace insurance, as eligible
3. Patient is assigned a level/cap on charges based on *individual* income provided
4. Insurance information and schedule of charges placement information is entered into billing system
5. All charges are billed to insurance initially (as applicable)
6. Schedule of charges is applied on amount owed by patient after insurance has assisted (if applicable)

Example Ryan White Enrollment Process

7. Patient is billed for amount owed based on the schedule of charges
8. The difference between the amount owed and the patient's responsibility is written off
9. Patient charge is applied to patient's cap on out of pocket charges
10. Program should check in with patient at a maximum of 6 months after enrollment to ensure nothing (insurance eligibility/income) has changed via self-attestation or documentation; patient recertifies
11. Income from insurance/patient payment (if applicable) is applied to program income and reinvested back into the Ryan White program

Sliding Fee Scale/Discount Schedule



DC | HEALTH HealthHIV

Important Definitions

- **Schedule of fees**: complete listing of Ryan White billable services and their associated fees
- **Schedule of charges**: a listing of reduced fees for services based on ability to pay. A schedule of charges may take the form of a sliding fee scale, discount on charges or a nominal fee
- **Nominal fee**: a type of charge that is a fixed/flat fee greater than zero for the provision of a Ryan White service
- **Discount on charges**: a type of charge that is a percentage of the full fee per the schedule

Ryan White Legislation: Patient Charges for Services

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)

Fiscal Monitoring Standards: Schedule of Charges

Imposition & Assessment 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

Fiscal Monitoring Standards: Clients Below 100% FPL

Imposition & Assessment of Client Charges

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

Fiscal Monitoring Standards: Clients Above 100% FPL

Imposition & Assessment of Client Charges

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

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

Implementing Fiscal Monitoring Standards

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

Ryan White 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

2018 Federal Poverty Guidelines

2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in Family/Household	Poverty Guideline
1	$12,140
2	16,460
3	20,780
4	25,100
5	29,420
6	33,740
7	38,060
8	42,380

DC | HEALTH HealthHIV

Ryan White & Other Schedule of Charges

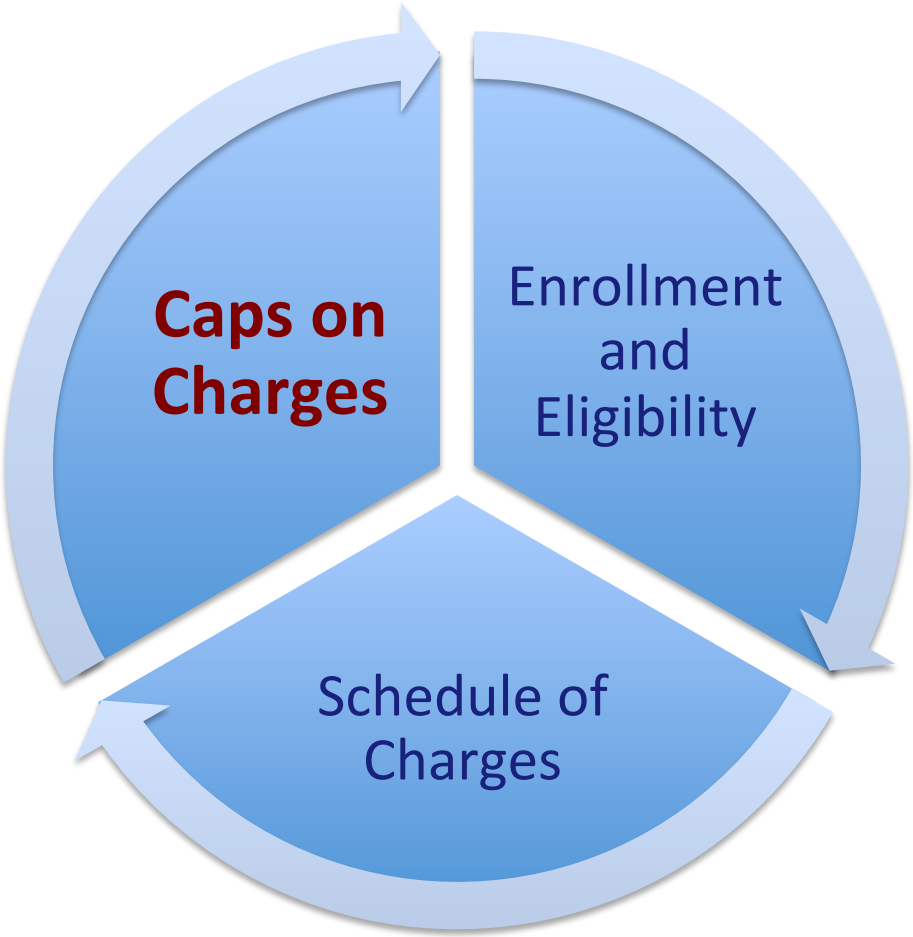
Some organizations already have a defined schedule of charges, (e.g., Federally Qualified Health Centers), but there are several important distinctions:

FQHC Schedule of Charges	Ryan White Schedule of Charges
Charges allowed for persons with income <100% FPL	No charges allowed for persons with income <100% FPL
Caps discount to persons with incomes at or below 200%	No cap on discount

Ryan White & Other Schedule of Charges

- If the organization's existing schedule of charges is in line with Ryan White legislation and program requirements, organizations can utilize the existing schedule of charges
- However, if the schedule of charges is not in compliance, the recipient will need to adopt a schedule of charges specific to the Ryan White program
  - E.g.: persons with incomes <100% of FPL cannot be charged for services

Caps on Charges



DC | HEALTH HealthHIV

Ryan White Legislation: Patient Cap 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

Calculating Patient Cap on Charges

- According to legislation, patient caps on charges are:
  - Based on an individual's FPL
  - Calculated and updated annually
  - Based on charges imposed, not 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 or coinsurance (PCN 13-05, 13-06, 14-01)

Universal Cap on Charges

Charges imposed on Ryan White clients should not exceed:

- 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

Schedule of Charges – Nominal Fee (Example)

Federal Poverty Level	Nominal Fee*
<100% FPL	$0
101-150% FPL	$5
151-200% FPL	$10
201-250% FPL	$15
251-300% FPL	$20
300% - 400% FPL	$25
>400% FPL	Full charge (up to cap)

* Up to the patient's assigned cap on charges

DC | HEALTH HealthHIV

Case Study 1 – Nominal Fee

- Person living with HIV
- Annualized income = $15,075
- FPL = 125%
- Cap on Charges: $753.75
- Patient has Medicare

Federal Poverty Level	Nominal Fee
101-150% FPL	$5

Case Study 1 – Nominal Fee

- 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 remaining $46.25
  - $5 is applied to patients cap on out of pocket charges ($753.75)

Federal Poverty Level	Nominal Fee
101-150% FPL	$5

Schedule of Charges – Percentage (Example)

Federal Poverty Level	Percentage Responsibility*
<100% FPL	0%
101-150% FPL	10%
151-200% FPL	20%
201-250% FPL	40%
251-300% FPL	60%
300% - 400% FPL	80%
>400% FPL	No discount (up to the cap)*

* Up to the patient's assigned cap on charges

Case Study 2 - Percentage

- Person living with HIV
- Annualized income = $18,814
- FPL = 156%
- Cap on out of pocket charges: $940.68
- Patient has private insurance

Federal Poverty Level	Percentage Responsibility
151-200% FPL	20%

Case Study 2 - Percentage

- Completes HIV-related medical appointment
- Insurance requires co-pay of $50
- Patient is charged fee = $10 (20%)
- Grant assists patient with remainder of the co-payment = $40 (80%)
- $10 is applied to patient's cap on out of pocket charges ($940.68)

Federal Poverty Level	Percentage Responsibility
151-200% FPL	20%

Case Study 3

- Person living with HIV
- Annualized income = $26,450
- FPL = 223%
- Cap on out of pocket charges: $1,851.50
- Patient is assessed for insurance and does not currently have insurance options

Case Study 3 – Nominal Fee

- Referred to specialty provider at another health center
- Completes HIV-related specialty medical appointment
- Full charge of appointment (per schedule of fees) is $150
- Patient is charged nominal fee of $15
- Ryan White assists with co-pays and remaining balance of $135 by paying specialty provider
- $15 is applied to patients cap on out of pocket charges on $1,851.50

Federal Poverty Level	Nominal Fee
201-250% FPL	$15

Case Study 3 - Percentage

- Referred to specialty provider at another health center
- Completes HIV-related specialty medical appointment
- Full charge of appointment (per schedule of fees) is $150
- Patient is charged $60, based on 40% discount per schedule of charges
- Program assists with remaining balance of $90 by paying specialty provider
- $60 is applied to patient's cap on out of pocket charges on $1,851.50

Federal Poverty Level	Percentage Responsibility
201-250% FPL	40%

Patient Education Tools

After-Enrollment Letter to identify the patient's:

- Placement within the program's schedule of charges
- 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

Ryan White HIV/AIDS Program Enrollment Verification Letter

Date:

Client Name:

Your application for the Ryan White HIV/AIDS Program (RWHAP) services has been completed. Your enrollment is effective .

Your sliding fee scale level is .
[*Your sliding fee scale level refers to how much you pay for HIV-related services here. The amount is based on your income.*]

Your out of pocket responsibility is .
[*This is the dollar amount or percentage that you pay when you receive a service here at the clinic.*]

Your cap on charges is $.
[*This is the maximum amount that you can pay for RWHAP services this year. This amount includes services here at our clinic, and other RWHAP services you might get somewhere else. If you reach this amount, you do not pay anything else for your RWHAP in that calendar year. If you have insurance, it will continue to be charged.*]

Charges that might apply to the cap: Insurance premiums, co-payments, deductibles for medical care and medications, and fees for services. Charges can occur on-site or through other medical providers.

IF YOU RECEIVE A BILL…..

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

RWHAP Benefits Manager 1 contact info:	**RWHAP Benefits Manager 2 contact info:**
Last Name, First Name **Email:** benefitsmanager1@email.com **Phone:** (123) 456-7891 Fax: (123) 456-7892 **Mail:** Enter clinic mailing address here	**Last Name, First Name** (se habla español) **Email:** benefitsmanager2@email.com **Phone:** (123) 456-7891 Fax: (123) 456-7892 **Mail:** Enter clinic mailing address here

DC | HEALTH HealthHIV

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

Date of Service	Provider	Brief Medical Description	Amount Due

DC | HEALTH HealthHIV

Patient Attestation Tools

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.

☐ **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

DC | HEALTH HealthHIV

Patient Attestation Tools

Self-Attestation
Statement of No Change

I _____, declare that there has been no change in my;
(print your name)

- ☐ 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)

DC | HEALTH HealthHIV

Discussion & Questions

THE EFFI BARRY
HIV/AIDS INSTITUTE

Managing Program Income

DC | HEALTH HealthHIV

Learning Objectives

- Identify sources of program income
- Recognize allowable uses of program income
- Review requirements of tracking, reporting, and spending program income
- Determine opportunities to maximize income to fill gaps in service delivery

Definition and Sources of Program Income

Definition of Program Income

Gross income earned by the non-Federal entity (Ryan White recipient or subrecipient) that is directly generated by a supported activity or earned as a result of the Federal award during the period of performance.

45 CFR 75.2; PCN 15-03

Program Income Requirements

- Programs are required to:
  - Maximize the service reimbursement available from private insurance, Medicaid, Medicare, and other third-party sources for reimbursable services provided
  - While program income must be maximized, Ryan White funds **cannot** be used to **supplement** the maximum cost allowance for services reimbursed by third party payments

Program Income Requirements, cont.

- Programs are required to:
  - Track and report all sources of service reimbursement as program income for each Ryan White Part/federal award on the annual Federal Financial Report and in competitive applications and non-competitive progress reports
  - Use program income earned to further the objectives of each Ryan White program
  - Program income attributed to the Ryan White program cannot be used for other (non-HIV) agency purposes

Sources of Program Income for Ryan White Programs

- Charges imposed on **and collected from** clients for services
- Funds received by billing public or private health insurance for services provided to eligible Ryan White clients
- Fees, payments, or reimbursement for the provision of a specific service, such as patient care reimbursements received under Medicare, Medicaid, or Children's Health Insurance Program
- The difference between the third party reimbursement and the 340B drug purchase price

Sources of Program Income Example: Michael

- Organization, "Cares", utilizes Ryan White Part C funds to support the salary of Dr. Jones, a Primary Care Physician, to provide HIV medical services to low-income individuals living with HIV
- Michael is a person living with HIV who has income below the federal poverty level and Medicare

Sources of Program Income Example: Michael

- Dr. Jones provides medical care to Michael and bills Medicare for all billable services provided
- Medicare pays "Cares" $55 for the services provided
- This $55 payment by Medicare for Michael's service is identified as program income

Program Income $55

Sources of Program Income Example: Michael Supplementing Maximum Cost

- Example of **supplementing** the maximum cost allowance (unallowable):
  - If organization Cares agrees to accept $55 from Medicare for Michael's visit, but the actual visit costs the organization $75, Ryan White Part C funds cannot be used to pay for, or account for, the $20 difference

Sources of Program Income Example: Miguel

- Miguel has an income that places him at 275% of the federal poverty level
- He receives HIV specialty care at the Red Clinic which is a Ryan White Part C funded agency
- Miguel is also enrolled to receive assistance from the state's Ryan White Part B program for insurance premium and co-payment assistance

Sources of Program Income Example: Miguel

- Miguel receives HIV medical care from Dr. Hall who receives salary support from Ryan White Part C funds
- Miguel pays $15 of his $40 insurance co-payment based on the Red Clinic's sliding fee scale
- The Red Clinic bills Miguel's insurance (Anthem) for all billable services provided and receives payment of $75
- Miguel's payment on the sliding fee scale ($15) and the amount paid for services by Anthem ($75) are counted as program income for the Red Clinic

Program Income - $90

Program Income Example: Miguel Duplicate Reimbursement

Q: What about the difference between the $40 co-payment owed and the $15 paid? Can the co-payment be billed to the Ryan White Part B program who assists with co-payments?

A: No, The Red Clinic cannot also bill the Ryan White Part B program for the services provided by Dr. Hall, because this service has already been paid for by Ryan White Part C funds - this would be considered a **duplicate reimbursement**.

Duplicate Reimbursement

- Direct (recipient) or indirect (subrecipient/ fee for service) grant funds such as Ryan White Part A, Part B, Part D, and Part F are not program income and cannot be used to duplicate reimbursement for services funded under Part C
- Additionally, services reimbursed by Ryan White Part C cannot also be billed to Ryan White Parts A, B, D, or F

340B Savings as Program Income

- All 340B generated revenue is considered program income
- When the Ryan White grant is the sole federal award that makes an organization eligible as a 340B covered entity, **all** program income should be attributed to the Ryan White grant
- When an entity is 340B eligible and purchases pharmaceuticals via 340B pricing under multiple federal awards, the recipient must:
  - Use a reasonable allocation method for attributing costs and program income
  - Be able to document the methodology used

340B Program Income Example: Tommy

- Tommy receives HIV medical care from the Ryan White Part C & D funded Blue Clinic
- Tommy's NP writes a script for a medication
- Tommy takes the script to the Blue Clinic's 340B pharmacy, which was received solely based on the clinic's Ryan White Part C & D funding
- The 340B price (discount) for the medication is $5
- Tommy does not have insurance, so he pays the $5 for the medication (the 340B price for the drug)
- There is no program income generated in this transaction

340B Program Income Example: Maria

- Maria receives HIV medical care from the Ryan White Part D funded Hope Clinic
- Maria's provider writes a script for an antiretroviral medication
- Maria takes the script to the Hope Clinic's 340B pharmacy, which was received solely based on the clinic's Ryan White Part D funding

340B Program Income Example: Maria

- The pharmacy orders the medication from an approved 340B supplier at $500 and bills Maria's insurance
- Maria's insurance company reimburses the pharmacy $1,100
- The Hope Clinic pays the manufacturer or distributor $500 for the medication
- The Hope Clinic keeps $600 as the 340B revenue, which is tracked as program income and reinvested back into the Ryan White program

Program Income $600

Income that is **not** Program Income

- Rebates: return part of a payment (specific to ADAP);
- Credits: transactions that offset or reduce expense items allocable to the federal award;
- Discounts: deductions in cost advance of a payment;
- Interest: earned on any of the above

Tracking Program Income

DC | HEALTH HealthHIV

Requirements for Tracking Program Income

- Per 45 CFR § 75.302(b), source and use of program income must be tracked and reported separately
- Financial Management Systems must provide identification, in its accounts, of all federal awards received and expended and the federal programs under which they were received
- Federal program and federal award identification must include as applicable:
  - The catalog of federal domestic assistance title and number (CFDA)
  - Federal award identification number and year
  - Name of the HHS awarding agency
  - Name of the pass-through entity, if any

Requirements for Tracking Program Income

- Financial Management Systems must provide records that adequately identify the source and application of funds for federally funded activities.
- Records must contain source documentation related to:
  - Federal awards
  - Authorizations
  - Obligations
  - Unobligated balances
  - Assets and expenditures
  - Income and interest

Requirements for Tracking Program Income

- An adequate accounting system for managing multiple budgets and funding streams
- A unique Account Number for each funding source/grant to ensure funds are sufficiently separated and tracked independently
- Internal systems to monitor income and expenditures
- Sufficient personnel (program and fiscal staff) to manage the award
- Routine financial reports to monitor compliance with Ryan White allowable expenditures

Strategies for Tracking Program Income

- Collaborate with billing or accounting departments
- Use reports from billing/payment systems to track payments (income) **during** that month (services may have been provided in previous months) for services that meet the program income requirements
  - Greater frequency (monthly) provides better accuracy and adjustment time to ensure program income is spent to further the objectives of the grant program during the performance period

340B Program Income: Allocation

- When the Ryan White grant is the **sole** federal award that makes an organization eligible as a 340B covered entity, **all** program income should be attributed to the Ryan White grant
- When an entity is 340B eligible and purchases pharmaceuticals via 340B pricing under multiple awards, the recipient must use a reasonable allocation method for the attribution of costs **and** program income, and be able to **document** the methodology used

Program Income Allocation Methods

- Program income cannot be prorated based solely on the size of the award
- Allocation could be based on:
  - The client that received the service - client level data and tracking of services
  - The service category and associated payer/funding source
  - The provider - based on supported FTE
- Allocation must include a review of the budget, explanation of how the award is being spent and allocated, and how those funds are generating revenue

Methods to Track Program Income

- Program income is generated by:
  - A person living with HIV (PLWH) receiving a specified HIV-related service or product (340B pharmaceutical)
  - At a Ryan White funded program
  - By a Ryan White funded provider
- Then the program receives an agreed upon third party payer payment for the service

Methods for Allocating Program Income

- Possible billing system modifiers
  - Patient diagnosis code (HIV)
  - Medication type (ART)
  - Ryan White specific provider
  - Location code (Ryan White clinic specific code)
  - Payer source
  - Secondary or tertiary insurance code to identify Ryan White eligible/enrolled patients

Tracking Program Income by Funding Source

- Patient factors
  - How is the patient enrolled?
  - What program are they eligible for?
- Personnel factors
  - What are the billable providers' funding sources?
  - How is the time and effort for the billable providers determined?

Tracking Program Income by Patient

- Define an enrollment and eligibility system that assesses patients for ALL eligible Ryan White Parts:
  - Federal Poverty Level (Part A/B determinant)
  - Sex/age (Part D determinant)
  - County/zip code of residence (occasionally Part A/B determinant)
- Document a system where patients can be assigned to multiple Parts/funding sources based on defined eligibility criteria

Tracking Program Income by Provider

- Determine funding levels by location and/or patients served
  - Assess providers' patient load by Ryan White Part-defining criteria: sex/age, zip code, federal poverty level, etc.
  - Assess patient load for HIV-positive patients versus HIV-negative patients (if integrated into a primary care or general ID clinic)
  - Consider location of service delivery: are all Part D patients seen at one clinic, while other patients are seen in another location?
- Time and effort has to be justifiable
  - systemic monitoring of service levels must be used to validate grant support (FTE) and program income

Client Level Assessment

- Service assignment and associated program income is based on the funding source of the person providing services and the eligibility criteria of the patient
- One funding source:
  - If a provider is funded fully by one funding source then 100% of patients served should be eligible and enrolled in the sole funding source
    - All program income would be attributed to the sole funding source

Client Level Assessment – Example 1

- Dr. Carter provides medical care two days per week at St. Francis Hospital, and three days per week she provides HIV specialty care at Morton Health Care
- 100% of Dr. Carter's effort at Morton Health Care is funded by the Ryan White Part C program
- All program income generated by Dr. Carter at Morton Health Care is tracked and attributed to the Ryan White Part C program

Client Level Assessment, cont.

- If a provider is funded by multiple grants then criteria used to determine/justify the multiple funding sources should be applied to the patients served:
  - Provider is funded by Part C and Part D based on % of PLWH served that meet WICY (women, infants, children, youth) definition
  - Program income should be calculated similarly

Client Level Assessment – Example 2

Dr. Ramirez provides HIV medical care two days per week at Mercy Medical Clinic

Dr. Ramirez	Number of Patients	Percentage of Patients	FTE
Ryan White Part C	150	75%	0.30
Ryan White Part D	50	25%	0.10
TOTAL	200	100%	0.40

Client Level Assessment – Example 2

Scenario 1

- 25% of the program income Dr. Ramirez generates at the Mercy Clinic is attributed to the Ryan White Part D program
- 75% of the program income Dr. Ramirez generates at the Mercy Clinic is attributed to the Ryan White Part C program

Scenario 2

- Patient SM is enrolled in the Ryan White Part D program and sees Dr. Ramirez
- Insurance and sliding fee scale payments generated by SM are tracked and attributed to the Ryan White Part D program

Tracking Program Income - Example

Journey Clinic receives Ryan White Part B, Part C, and Part D funding

Ryan White Part	Eligibility Criteria
B	PLWH with income less than 300% of the federal poverty level in 5-county service area
C	PLWH on a discounted fee schedule
D	Women (Ages ≥25), Infants (Ages <2), Children (Ages 2-12), Youth (Ages 13-24)

Tracking Program Income - Example

Journey Clinic receives Ryan White Part B, Part C, and Part D funding

Personnel	Description of Services	FTE		
		Part B	Part C	Part D
Dr. Matthews	Provides two clinic sessions per week to low income PLWH – provider reports show that Dr. Matthews serves 20% WICY patients	0.00	0.16	0.04
Mr. Davis	Provides mental health counseling services 5 clinic sessions per week	0.50	0.00	0.00
Dr. Smith	Provides psychiatric services 1 clinic session per week	0.00	0.10	0.00

Tracking Program Income - Example

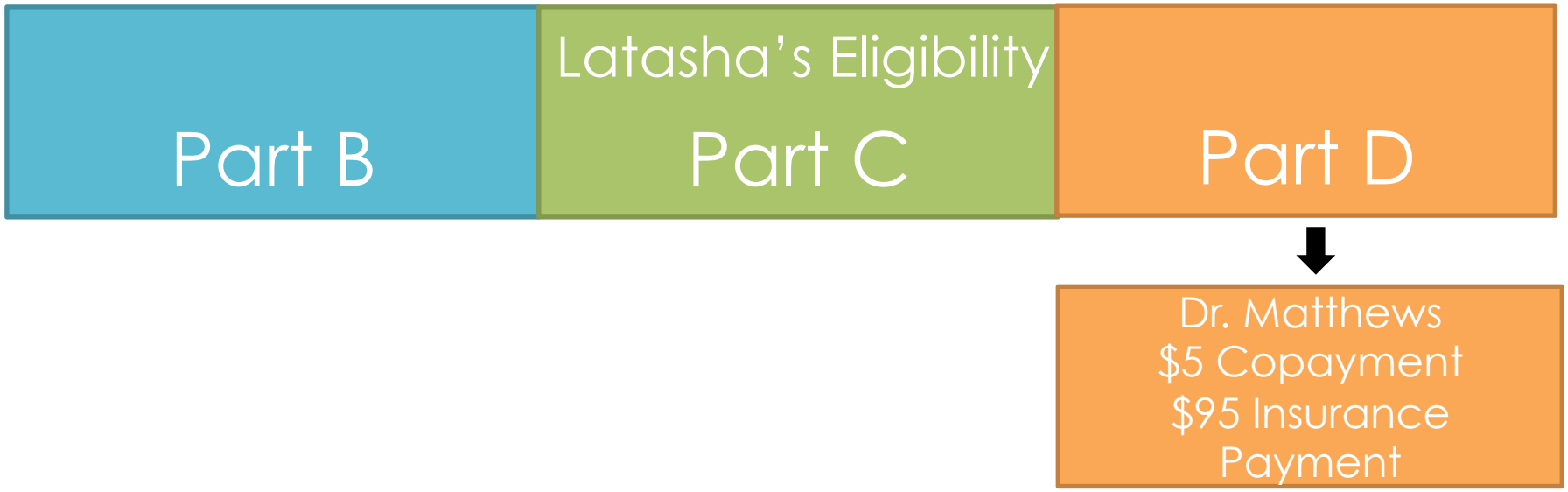
- Latasha receives HIV medical care from the Ryan White Part B/C/D-funded Journey Clinic
- She is living with HIV, 22 years old, and has an income at 183% of the federal poverty level
- Latasha is eligible and enrolled in Journey Clinic's Ryan White Part B, C, and D programs
- Latasha has private insurance through her employer that requires a $10 co-payment for medical services and a $25 co-payment for mental health and psychiatric services
- Based on Journey Clinic's discounted fee schedule, Latasha is responsible for $5 per service

Tracking Program Income - Example

- Latasha receives medical care from Dr. Matthews
- Latasha pays a $5 co-payment per Journey Clinic's discounted fee schedule
- Journey Clinic bills Latasha's insurance for the medical services and receives agreed upon payment of $95
- Since Dr. Matthews' funding is split based on Ryan White Part D and Part C eligible patients, Latasha's visit is considered a Part D service (she is Part D eligible) and the income generated is tracked as Part D income = $100 ($95 + $5)

Personnel	Description of Services	FTE		
		Part B	Part C	Part D
Dr. Matthews	Provides two clinic sessions per week to low income PLWH – provider reports show that Dr. Matthews serves 20% WICY patients	0.00	0.16	0.04

Tracking Latasha's Program Income

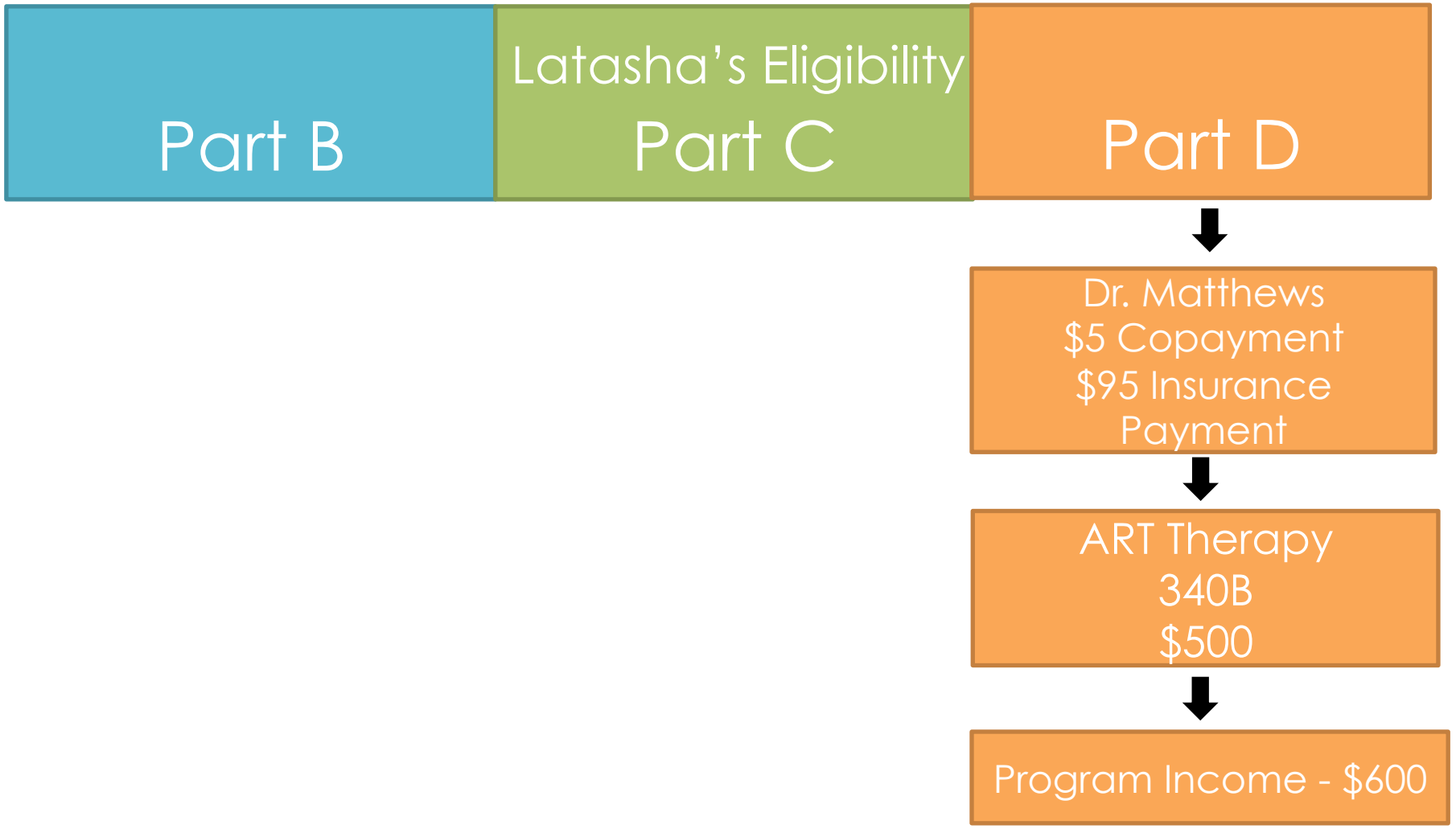


DC | HEALTH HealthHIV

Tracking Program Income - Example

- Dr. Matthews prescribed Latasha's ART regimen
- Latasha fills the script in the Journey Clinic's 340B pharmacy which was received due to Ryan White Part C/D funding
- The pharmacy orders the medication from an approved 340B supplier at $500 and bills Latasha's insurance
- Latasha's insurance company reimburses the pharmacy $1,000
- Journey Clinic pays the manufacturer or distributor $500 for the medication
- The clinic keeps $500 as the 340B revenue, which is tracked as program income for the Ryan White Part D program and reinvested back into the Ryan White Part D program

Tracking Latasha's Program Income



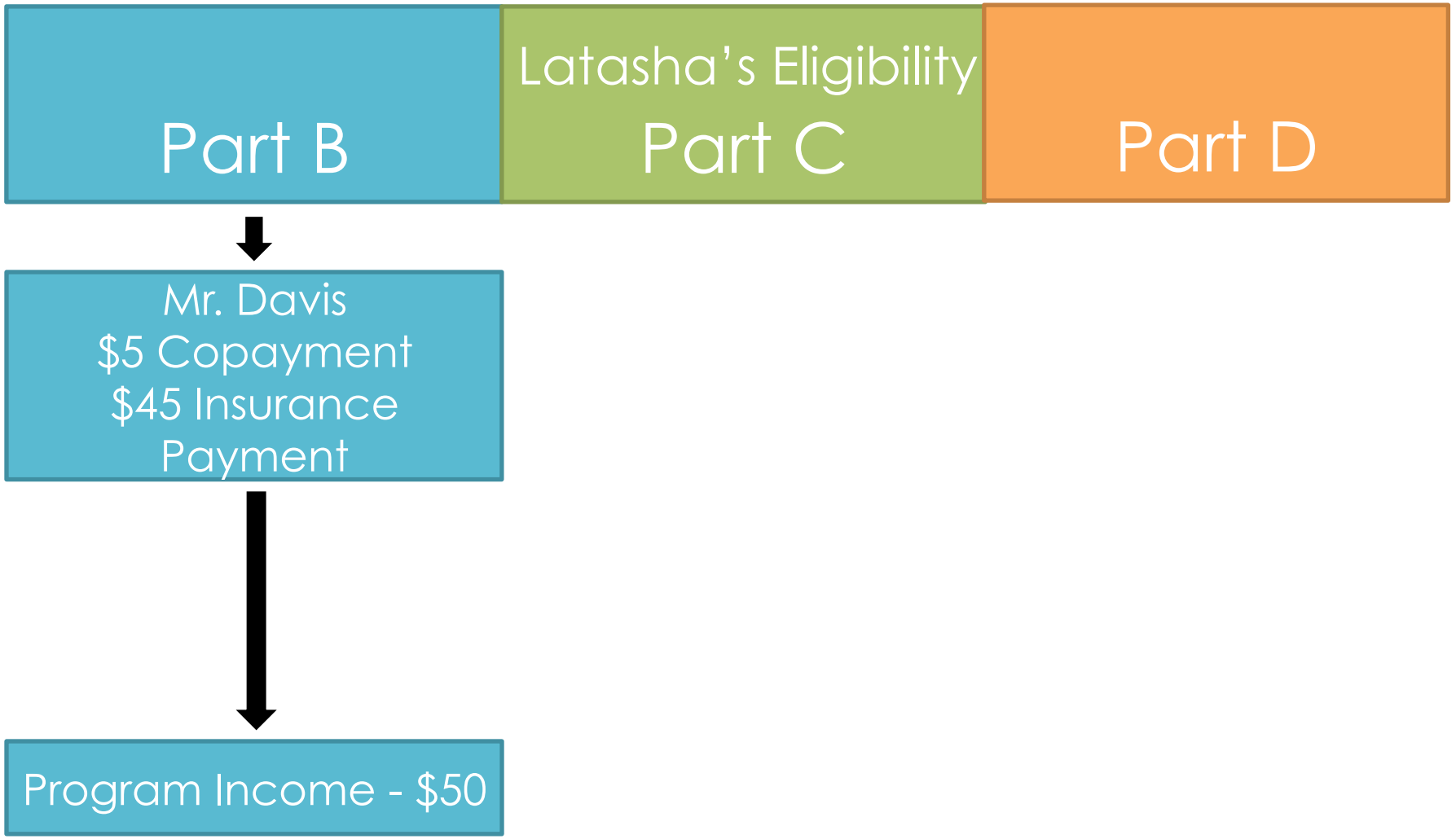
DC | HEALTH HealthHIV

Tracking Program Income - Example

- Latasha sees Mr. Davis for mental health services
- Latasha pays a $5 co-payment per Journey Clinic's discounted fee schedule
- Journey Clinic bills Latasha's insurance for the mental health services and receives agreed payment of $45
- Since Mr. Davis' funding is solely Ryan White Part B, Latasha's mental health visit is considered a Part B service and the income generated is tracked as Part B income ($50)

Personnel	Description of Services	FTE		
		Part B	Part C	Part D
Mr. Davis	Provides mental health counseling services 5 clinic sessions per week.	0.50	0.00	0.00

Tracking Latasha's Program Income



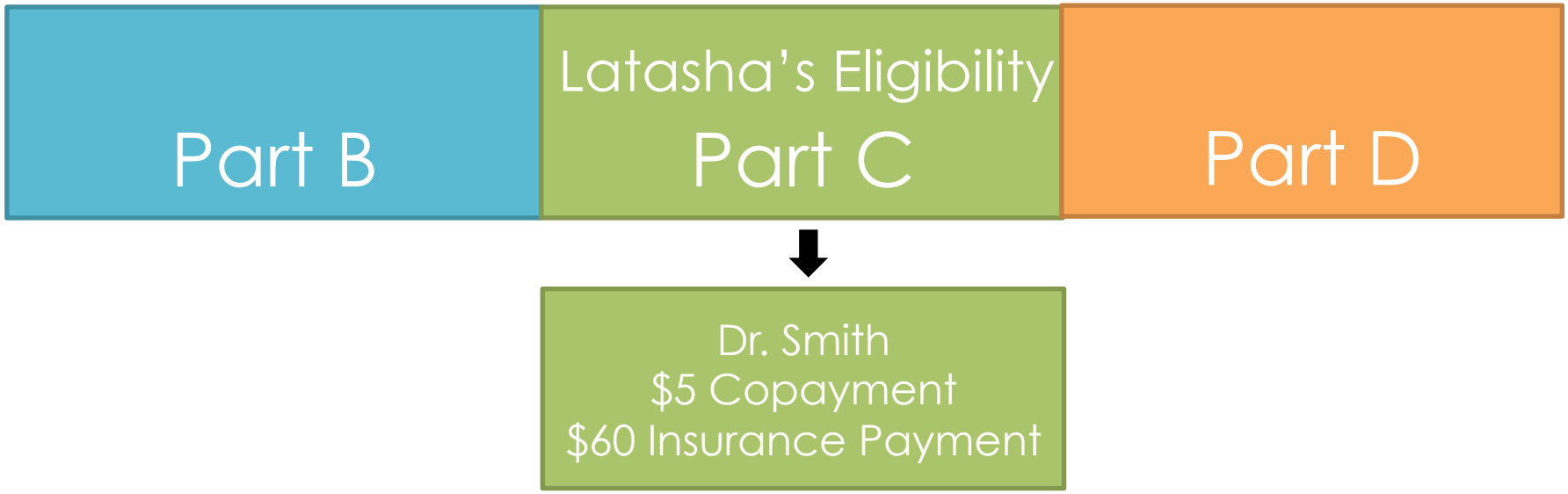
DC | HEALTH HealthHIV

Tracking Program Income

- Mr. Davis refers Latasha to Dr. Smith for psychiatric services
- Latasha pays a $5 co-payment per Journey Clinic's discounted fee schedule
- Journey Clinic bills Latasha's insurance for the psychiatric service and receives agreed upon payment of $60
- Since Dr. Smith's funding is solely Ryan White Part C, Latasha's mental health visit is considered a Part C service and the income generated is tracked as Part C income = $65

Personnel	Description of Services	FTE		
		Part B	Part C	Part D
Dr. Smith	Provides psychiatric services 1 clinic session per week	0.00	0.10	0.00

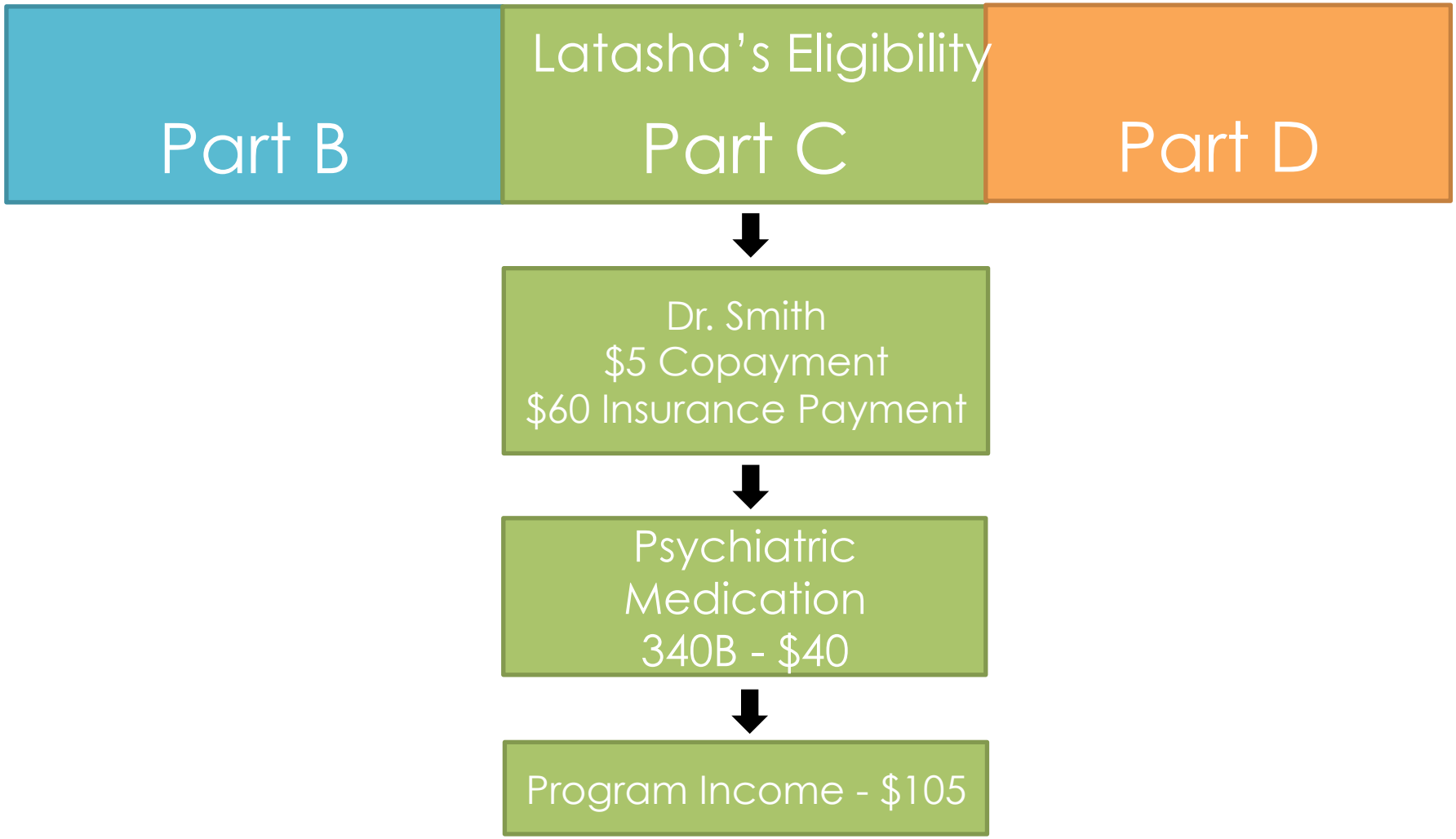
Tracking Latasha's Program Income



Tracking Program Income

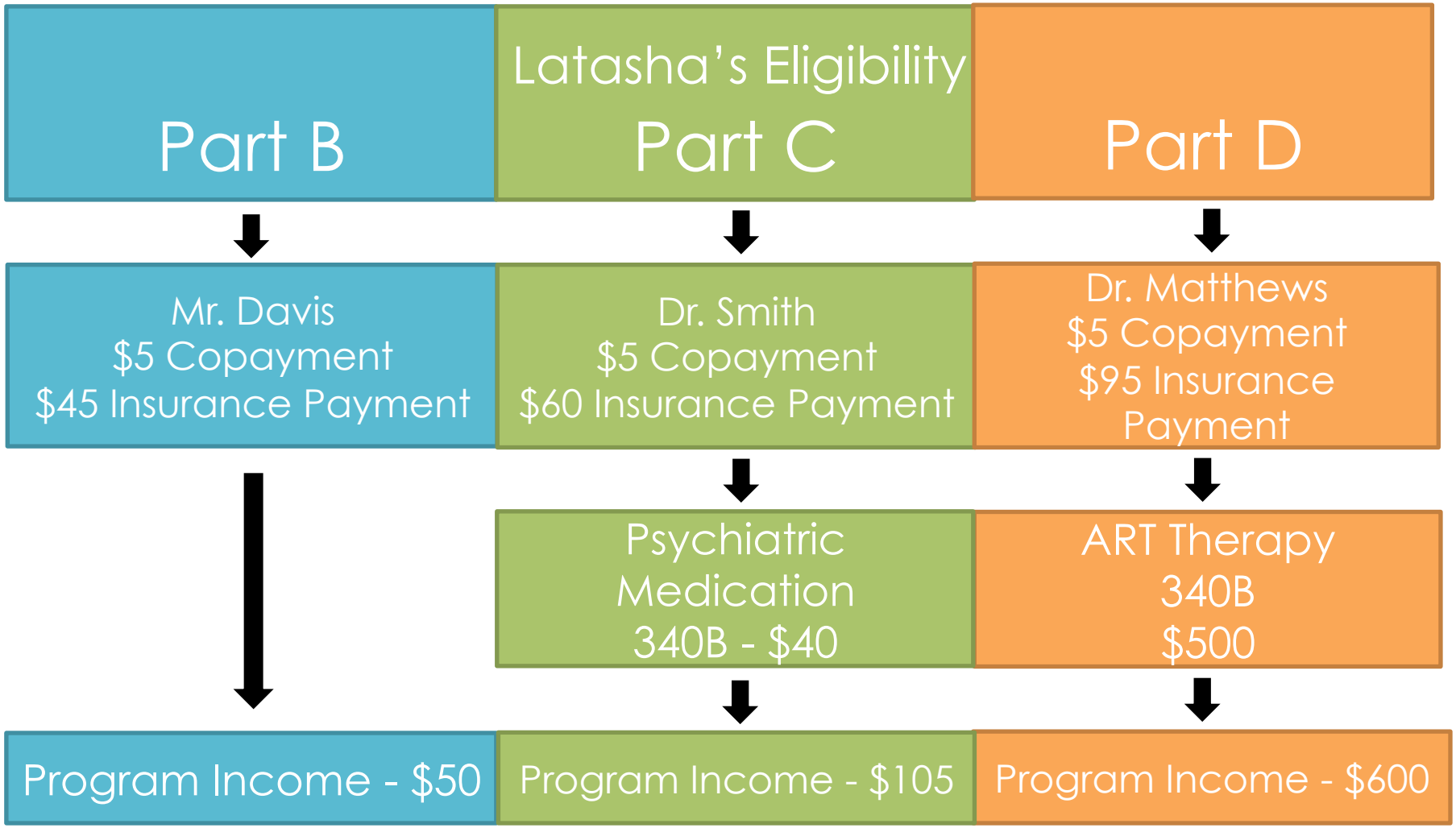
- Dr. Smith prescribes a psychiatric med. for Latasha
- Latasha fills the script in the Journey Clinic's 340B pharmacy
- The pharmacy orders the medication from an approved 340B supplier at $60 and bills the patient's insurance
- Latasha's insurance company reimburses the pharmacy $100
- Journey Clinic pays the manufacturer or distributor $60 for the medication
- The clinic keeps $40 as the 340B revenue, which is tracked as program income for the Ryan White Part C program and reinvested back into the Ryan White Part C program

Tracking Latasha's Program Income



DC | HEALTH HealthHIV

Tracking Latasha's Program Income



DC | HEALTH HealthHIV

Allowable/Unallowable Uses of Program Income

Program Income as "Additive"

- 45 CFR § 75.307 (e) – Program income options
  - Additive
  - Deductive
  - Combination
  - Matching
- Deductive is the federal default
- HAB identifies in the NOA how program income is to be treated: Additive
- Additive means that income is "added to funds committed to the project or program and used to further eligible project or program objectives"

Program Income as "Additive"

- Under the Additive alternative, program income "must be used for the purposes and subject to the conditions of the federal award"
- Program income is added to the grant award but may only be used:
  - For allowable costs under the award to expand the program and to further the objectives of the Ryan White program

Utilizing Program Income

- Program income can support allowable activities in excess of statutory caps that are imposed directly by Ryan White, such as:
  - Administrative costs (10%)
  - Indirect Costs
  - CQM
  - Core Medical (75%)
  - EIS (50%)

Allowable Uses of Program Income

- For Ryan White Parts A, B, and C, allowable costs are limited to:
  - Early Intervention Services
  - Core medical services
  - Support services
  - Clinical Quality Management (CQM)
  - Administrative expenses (including planning & evaluation) as part of a comprehensive system of care for low-income individuals living with HIV

Allowable Uses of Program Income

- For Part D, allowable costs are limited to services to women, infants, children and youth affected by or living with HIV:
  - Family centered care involving outpatient or ambulatory care
  - Support services
  - CQM
  - Administrative expenses

Allowable Uses of Program Income

- Part F costs are limited according to appropriate statutory provision:
  - AIDS Education and Training Center
  - Special Projects of National Significance
  - Dental Reimbursement Program
  - Minority AIDS Initiative

Unallowable Uses of Program Income

- Staff Salaries:
  - Ryan White recipient and subrecipients may not use award funds or related program income to pay the salary of an individual at a rate in excess of Executive Level II, currently at $189,600 as of January 7, 2018.

Frequently Asked Questions for Policy Clarification Notices 15-03 and 15-04 HRSA/HAB

Unallowable Uses of Program Income

- Dr. Marshall makes an organizational salary of $213,000
- She provides medical services to low-income people living with HIV for two clinic sessions a week (0.2 FTE)
- Dr. Marshall's salary on the Ryan White Part D grant is capped at $189,600, or $37,920 based on FTE (0.20 FTE)
- The real organizational cost of Dr. Marshall's salary at 0.2 FTE is $42,600 ($213,000 * 0.20 FTE)
- Program income can not be used to pay for the $4,680 difference ($42,600 - $37,920)

Dr. Marshall	Salary	FTE	Salary Support
Organizational	$213,000	0.20	$42,600
Executive Level II	$189,600	0.20	$37,920
Difference	$23,400	0	$4,680

Unallowable Uses of Program Income

- Construction and or major alteration or renovation
- Cash payments to recipients of Ryan White services
- HIV "related" but unallowable services under Ryan White
  - Needle exchange
  - Post- or pre-exposure prophylaxis (PEP or PrEP) medications or medical services
  - In-patient or emergency related expenses for people living with HIV

Budgeting of Program Income

DC | HEALTH HealthHIV

Budgeting with Program Income

- Program income must be used on Ryan White allowable costs
- However, program income is not directly federal funds, therefore:
  - Funds can be used for services that are allowable, but are not in the grant budget
  - Funds can be used to expand the scope of services

The Bigger Picture

- Estimate the larger needs, not just the needs covered by the grant funds
- Review PCN 16-02 "Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds" to consider all possible services that can be funded under the Ryan White program
- Review virally unsuppressed patients - look at barriers preventing suppression
- Consider budgeting funds in categories that will achieve viral suppression for those patients who are hardest to reach

Budgeting with Program Income

- Estimate (to the extent possible) how much program income will accrued
- Best practices include developing a plan to spend down program income simultaneously, so as not to have unobligated balance (UOB) on the federal award
- Budget program income to **complement, not replicate** services already funded directly by Ryan White grant funds

Program Income Planning

- Budget and Program Expenditures should be built off a combination of grant funds, subcontracts, organizational support, and program income

Grant/Income	Amounts
Federal Grant Funds	$550,000
State Subcontract	$250,000
Total Grant Funds	$800,000
Projected Program Income	$1,200,000
Total Program Funding	$2,000,000

- Budget and spending should be based on $2,000,000, not $800,000

Budgeting with Program Income

Recipients must:

- Include program income projections when planning for services, based on the comprehensive HIV care and treatment needs of the recipient's service area
- Develop a reasonable and transparent process for budgeting and expending federal funds and related program income
- Ensure spending is in line with program requirements, program reporting, and fiscal requirements

Budgeting with Program Income

- Review the required and proposed goals/ objectives of each funding source (grants, subcontracts, income)
- Assess your entire program looking at all funding streams and expenses to obtain an accurate picture of the program's finances
- Prepare a flow chart or table that identifies what each grant is allowed to pay for to ensure the funds are utilized correctly
- Define how patients, services, and providers are supported to streamline the process.

Budgeting with Program Income

- Set up a proposed line-item budget for program income just as you would for a federal award
- Monitor income and expenditures as often as possible
- Expect this process to be more dynamic then a federal award; as income fluctuates so must the plan to spend
- Monitor the program income to ensure funds are being received as anticipated
- Ensure spending is in line with proposed budget and does not need to be adjusted due to fluctuation in income

Budgeting for Multiple Funding Streams

Line Item	RWA	RWA Program Income	RWC	RWC Program Income	TOTAL
Outpatient Medical Care	$ 70,000	$ 105,000	$ 90,000	$ 100,000	$ 365,000
Laboratory/Radiology	$ 65,000	$ -	$ 15,000	$ -	$ 80,000
Medical Case Management	$ 70,000	$ -	$ 65,000	$ -	$ 135,000
Mental Health Services	$ 55,000	$ 60,000	$ 15,000	$ 20,000	$ 150,000
Substance Abuse Services	$ -	$ -	$ 30,000	$ 95,000	$ 125,000
Psychosocial Support Services	$ 12,000	$ -	$ 15,000	$ -	$ 27,000
Pharmaceuticals	$ 56,000	$ -	$ 8,000	$ -	$ 64,000
Medical Transportation	$ 7,000	$ -	$ 5,000	$ 20,000	$ 32,000
Insurance Program	$130,000	$ -	$ -	$ 20,000	$ 150,000
Administration	$ 65,300	$ -	$ 26,200	$ -	$ 91,500
Total Award	$530,300	$ 165,000	$ 269,200	$255,000	$1,219,500

DC | HEALTH HealthHIV

Spending Program Income

Utilizing Program Income

- **To the extent available, recipients and subrecipients must disburse funds available from program income** before requesting additional cash payments (45 CFR § 75.305 (b) (5))
- Recipients/subrecipients should strive to proactively secure and estimate the extent to which program income will be accrued.
- This is done to effectively determine the need for Ryan White funds and their allocation and utilization during the current performance period

The Goal of Budgeting, Tracking, & Spending Program Income

- 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
  - Fill 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
- Proper management and program design can ensure that all funding sources work together to provide a full range of services

Discussion & Questions

THE EFFI BARRY
HIV/AIDS INSTITUTE

Reporting Time and Effort

DC | HEALTH HealthHIV

Learning Objectives

- Review the Uniform Guidance for HHS awards as it pertains to time and effort reporting or timekeeping
- Describe industry practices for timekeeping
  - Rigorous procedures with strong internal controls
  - Sample rules for time and effort reporting
- Indicate time and effort requirements that most impact Ryan White programs

Time and Effort Reporting Requirements: Regulations

DC | HEALTH HealthHIV

Site Visit Questions

Payroll and employees' time and effort:

- Are employees required to complete time and effort reports?
- Are the time and effort reports reviewed and signed by the employee's supervisor?
- Is payroll subject to final approval before payment by a responsible official or by another person who is independent of payroll preparation and timekeeping?
- Does the recipient have an adequate system to verify that the actual time worked is consistent with the allocations of time and effort included in the RWHAP budget?
- Are the workload reports, e.g. number of primary care visits, consistent with the allocations of employees' time and effort?

45 CFR 75.430 (i) – New Time Reporting Regulations

Standards for documenting personnel expenses:

- Charges to awards for salaries must be based on records that accurately reflect the actual work performed
  - Supported by a system of internal controls that reasonably assure that the charges are accurate, allowable, and properly allocated
  - Incorporated in the official policies & procedures of the recipient and subrecipient

75.430 (i) – New Time Reporting Regulations

In other words, time and effort procedures **must** include a review process where employees (and their supervisors) can make sure that the hours they report are equal to the actual hours worked and billed to the proper project code.

Time & Effort Log

- Federal regulations do not prescribe a specific form or style of reporting. Timesheets are one example of an acceptable system.
- Should include a statement similar to "I/we certify that to the best of our knowledge the above allocation of time expended performing Federal, State, and other program duties is true and accurate."

Time & Effort Log

- Time & effort reporting must:
  - Account for 100% of employees' compensated time
  - Must not exceed 1.0 FTE
- Residual categories (non-federal sources) do not have to be documented in detail (can be a lump-sum balance of compensated time)

Standards for Documenting Personnel Expense

Budget estimates ➡ after-the-fact charges (actual)

- Need to review after-the-fact charges made to awards
- All necessary adjustments must be made so the final amount charged to award are accurate, allowable and properly allocated
- Since practices vary as to the activity constituting a full workload, institution of higher education (IHE) records may reflect categories of activities expressed as a percentage distribution of total activities

Timekeeping Preparation

- Time studies are not permitted for non-profit organizations or institutes of higher education [per 200.430(i)(5)], only permitted for state, local and tribal units of government
- Time studies only allowed for budget estimates for non-governments, not as verification of actual hours worked

Time Reporting: Responsibility

- The financial administrator will administer the timekeeping procedure; provide employee orientation, training, and perform periodic timekeeping reviews to ensure compliance with this policy
- Management is responsible for ensuring the timekeeping system is compliant
- Employees are responsible for following the timekeeping procedures established in their policy

Time Reporting: Training

If an employee becomes aware that they have been directed to charge an activity that the employee is not currently working on, i.e., to mischarge, the employee should report it to the HHS Office of Inspector General at http://oig.hhs.gov/fraud/report-fraud/index.asp.

- Example: settlements with universities due to the lack of support for time and effort

Time and Effort Reporting Requirements: Implementation

DC | HEALTH HealthHIV

Timekeeping Preparation

Recommendation that timesheets are completed on a daily basis

- Or posting to some type of notepad as the charges are incurred, and then posting on the timesheet at the end of the bi-weekly or semi-monthly payroll
- If an employee waits until the end of the pay period to post his/her time charges, he/she will most likely forget and the time will not be accurate
- Maintaining time on a daily basis avoids inaccurate timekeeping which avoids potential false claims

Verifying/Certifying

- Must be signed by either the employee and other responsible individual with knowledge of the employee's activity (i.e. supervisor)
- Institution must have suitable means of verifying the accuracy of the time and effort reports
  - Workload reports
  - Meeting minutes
  - Project management tracking

Support Documentation

- Suggested supporting documentation includes:
  - Schedule that reflects actual work
  - Personnel activity reports/timesheets
- Unacceptable supporting documentation includes:
  - Estimating/prorating based on patient population or program budget size, budgeted or projected figures, time studies (except for governments), or percentages written into a position description

Support Documentation

- For positions that have multiple funding sources and cost categories, the question to ask is:
  - How was the amount of salary and benefits charged to the grant determined for this position?
- Supporting documentation must reasonably assure an individual reviewing it that the costs were accurate and properly allocated

Aiming for Reasonable

The goal of reporting and supporting time & effort is not to document every minute worked, but to allow an auditor to determine that the amount of time charged to a particular grant is reasonable

- 100% funded positions face less scrutiny – based on patient population, is time spent on grant activities reasonable?
- For positions funded by multiple sources, keeping an eye out for mischarging

Support Documentation per Position

Position Types	Possible Supporting Documentation
Billable patient care providers (Physician, PA, NP, Mental Health Providers, etc.)	• Registration lists - arrived appointments • Electronic health record notes • Billing reports • Daily time and effort logs
Non-billable patient care (medical case manager, dietician, pharmacist, health educators, etc.)	• Registration lists - arrived appointments (if there is an associated schedule for the employee) • Electronic health record notes • Service encounters • Daily time and effort logs
Administrative staff	• Calendar reports (standing/scheduled meetings) • Daily time and effort logs

Time & Effort Scenario 1

- A Ryan White outpatient ambulatory medical center operates as part of a university-based hospital system
- Faculty/physicians record time monthly, supervisors do not review
- Principle Investigator is supported by a combination of Part C & Part D funds

Funding Source	Total FTE	Core Medical/ Medical Service	CQM	Administration
Part C	0.18	0.15	0.01	0.02
Part D	0.09	0.07	0.01	0.01

Time & Effort Tracking

Medical Providers/Mental Health Counselors/Dieticians

Areas of Consideration	Time & Effort Methodology/ Supporting Documentation
Patient load HIV/HIV-affected vs. non-HIV	• Daily/weekly patient level productivity reports (registration and/or billing system; electronic health record)
Patient load WICY vs. non-WICY	
Standing meetings associated with RWHAP (Administrative, Clinical, CQM)	• Weekly/monthly calendar review • Monthly log of standing meetings • Time & effort report
Supervision of RWHAP staff	
Protocol/policies development	
CQM project implementation	

DC | HEALTH HealthHIV

Time & Effort Log: Monthly Example

Personnel Time and Effort Report

Employee Name Dr. Jones **Employee Number** 1234567

Date Range 4/1/2016 through 4/30/2016

		Funding Source 1 RWHAP Part C			Funding Source 2 RWHAP Part D			Funding Source 3	Funding Source 4	Total Hours
Date		Core Medical	CQM	Admin	Medical Services	CQM	Admin	Non-Federal Funding		
1	Friday	0.75			0.25			7		8
4	Monday	3		0.75	1		0.25	3		8
5	Tuesday	4						4		8
6	Wednesday							8		8
7	Thursday							8		8
8	Friday	0.75			0.25			7		8
11	Monday	2		0.75	2		0.25	3		8
12	Tuesday	3			1			4		8
13	Wednesday			0.75		0.25		7		8
14	Thursday							8		8
15	Friday	0.75			0.25			7		8
18	Monday	2		0.75	2		0.25	3		8
19	Tuesday	1			3			4		8
20	Wednesday							8		8
21	Thursday							8		8
22	Friday	0.75			0.25			7		8
25	Monday	4		0.75			0.25	3		8
26	Tuesday	3			1			4		8
27	Wednesday							8		8
28	Thursday							8		8
29	Friday	0.75			0.25			7		8
Total Hours		25.75	0	3.75	11.25	0.25	1	126	0	168
Percentage		15%	0%	2%	7%	0%	1%	75%	0%	

We certify that to the best of our knowledge the above allocation of time expended performing Federal, State, and other program duties is true and accurate.

Employee Signature _____

Supervisor Signature _____

DC | HEALTH HealthHIV

Time & Effort Scenario 1

Recommendations:

- Faculty/physicians track time daily, even if they do not have to submit very often
- Supervisors review their timesheets, providing patient level productivity reports to verify time worked

Time & Effort Scenario 2

- A Ryan White outpatient ambulatory medical center operates as part of a university-based hospital system.
- Employees use an electronic time system, and employees complete time verification daily via clock-in/clock-out procedures.
- The supervisor signs off on the timesheets every two weeks.
- The budget is charged through a pre-determined percentage of effort.
- The Program Coordinator is 100% federally grant funded through a percentage of four projects and various cost categories.

Funding Source	Total FTE	CQM	Support Services	Administration
Part C	0.55	0.15	0.15	0.25
Part D	0.30	0.05	0.05	0.20
Part B	0.10	0.00	0.00	0.10
AETC	0.05	0.00	0.00	0.05

Time & Effort Tracking

Program Coordinators/Data Administrative Staff

Areas of Consideration	Time & Effort Methodology/ Supporting Documentation
Role per funding source	• Weekly calendar review • Monthly log of standing meetings • Daily time & effort log
Duties/roles that simultaneously serve multiple parts/funding sources	
Payment of bills/data entry and associated funding sources	
Standing meetings associated with RWHAP (administrative, clinical, CQM)	
Supervision of staff	
Protocol/policies development	

Time & Effort Log: Weekly Summary

Employee Name	Jane Doe	**Employee Number**	3456789
Date Range	5-Jun-16 through	11-Jun-16	

	Project 1			Project 2			Project 3	Project 4	Project 5	Project 6	
	RWC			RWD			RWB	AETC			
Day	**CQM**	**Support Service**	**Administration**	**CQM**	**Support Service**	**Administration**	**Administration**	**Administration**			**Total Hours**
Sunday	0.00	0.00	0.75	0.00	0.00	0.25	0.00	0.00			1.00
Monday	0.25	0.75	3.00	0.25	0.25	1.75	1.00	0.50			7.75
Tuesday	0.25	0.75	3.00	0.25	0.25	1.75	1.00	0.50			7.75
Wednesday	1.00	0.00	3.00	0.50	0.00	1.75	1.00	0.50			7.75
Thursday	0.25	1.00	3.00	0.25	0.50	1.75	0.50	0.50			7.75
Friday	0.25	0.75	3.00	0.25	0.25	1.75	1.00	0.50			7.75
Saturday	0.75	0.00	0.00	0.25	0.00	0.00	0.00	0.00			1.00
Total Hours	2.75	3.25	15.75	1.75	1.25	9.00	4.50	2.50			40.75
Percentage of Effort	7%	8%	39%	4%	3%	22%	11%	6%			**1**

We certify that to the best of our knowledge the above allocation of time expended performing Federal, State, and other program duties is true and accurate.

Employee Signature _____

Supervisor Signature _____

DC | HEALTH HealthHIV

Time & Effort Scenario 2

Recommendation

- Budget must be charged according to actual hours worked, not budgeted (allocated) time.

Time & Effort Scenario 3

- Community-based organization receives RWHAP Part C & D funding.
- Employees use electronic time sheets that are completed bi-weekly, and the supervisor signs off on their timesheets every two weeks.
- The budget is charged based on pre-determined percentages.
- Clinical Nurse is funded at 20% RWHAP Part C, 10% RWHAP Part D and is funded at 70% through agency funds.

Funding Source	Total FTE	Core Medical/Medical Service Delivery	CQM
Part C	0.20	0.15	0.05
Part D	0.10	0.09	0.01

Time & Effort Tracking

Nurses/Clinical Services Techs

Areas of Consideration	Time & Effort Methodology/ Supporting Documentation
Patient load HIV/HIV-affected vs. Non-HIV	• Daily/weekly patient level productivity reports (registration system; electronic health record) • Patient encounter notes
Patient load WICY vs. non-WICY	
Standing meetings associated with RWHAP (administrative, clinical, CQM)	• Weekly calendar review • Monthly log of standing meetings • Daily time & effort log • Productivity report
Supervision of RWHAP staff	
Protocol/policies development	
CQM project implementation	

Time & Effort Log: Bi-Weekly Example

Bi-Weekly Time and Effort Report

Employee Name _____

Employee Number _____

Date Range _____

Date	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Total Hou	Percentage
Program Funding Source															0	0%
Ryan White Part C		2	1	2	0	0			0	1	1	4	4		15	21%
Ryan White Part D		1	0	1	1	0			0	0	1	2	1		7	10%
Other Agency Funds		5	7	5	7				8	7	6	2	3		50	69%
															0	0%
															0	0%
Total Program Hours	0	8	8	8	8	0	0	0	8	8	8	8	8	0	72	1
Annual Leave						8									8	
Sick Leave															0	
Compt Time															0	
Holiday Pay															0	
Total Paid Hours	0	8	8	8	8	8	0	0	8	8	8	8	8	0	80	
Leavel Without Pay															0	

We certify that to the best of our knowledge the above allocation of time expended performing Federal, State, and other program duties is true and accurate.

Employee Signature _____

Supervisor Signature _____

DC | HEALTH HealthHIV

Time & Effort Scenario 3

Recommendation

- Budget must be charged according to actual hours worked, not allocated time.

Time & Effort Checklist

- ❑ Budget with *estimated* FTE and compensation
- ❑ Time & effort log (timesheet, time card) reflecting *actual* hours worked
- ❑ Supervisor reviews to verify actual hours worked and gives approval
- ❑ Reconciliation with budget: must reflect hours worked, not hours estimated
- ❑ Document time & effort reporting policies and procedures
- ❑ Maintain supporting documentation for site visits and audits

Discussion & Questions

Contact

Shayna Linov
Shayna@HealthHIV.org

Michael Shankle
Michael@HealthHIV.org

www.HealthHIV.org

DC | HEALTH HealthHIV

Upcoming Meetings & Events

The National Conference for HIV, HCV, and LGBT Health

April 14 -16, 2019
Washington, DC

DC | HEALTH HealthHIV