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Payor of Last Resort

PURPOSE

The purpose of this policy is ensure compliance with the Ryan White Treatment and Modernization Act and to maximize limited program funds establishing DSHS funding, including Ryan White and State Services, as the payor of last resort.

AUTHORITY

Ryan White HIV/AIDS Treatment Modernization Act, 2006; Texas Health and Safety Code, Chapters 12 (§12.052, §12.083) and 85 (§85.032)

DEFINITIONS

- CHIP Children’s Health Insurance Program is designed for families who exceed the income limits for Medicaid, yet cannot afford to buy private health insurance for their children.
- Family A household composed of two or more related persons or a household relationship based on responsibility for the care and well-being of others. A person who is not a relative by blood or marriage can be considered a family member if they are important to the care or well-being of a person with HIV. This does not include a live-in aide who is compensated to provide care.
- Client Fee An amount of money a client is expected to contribute to the cost of their medical care, either on sliding scale of flat fee basis. The amount may be predetermined by the client’s third party payor (i.e., co-payment for medical insurance).
- Flat Fee A system used to charge clients without a billable third party payor. Agencies can charge flat fees for medical services per service (e.g., \$10 per office, \$5 per lab) up to a maximum based on individual or family annual gross income.
- Medicaid A state and federal cooperative program that provides medical coverage to eligible needy persons.
- Medical Care Any reference in this policy to medical care refers to HIV ambulatory medical care for HIV positive clients

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2	Medicare	A federally-funded health insurance program for people age 65 or
3		older, people under 65 with certain disabilities, and people of all
4		ages with end-stage renal disease
5		
6	Sliding Scale Fee	A system used to charge clients without a billable third party payor.
7		Sliding scale fees are based on the cost of itemized services
8		received and family annual gross income
9		
10	Third Party Payor	Any health insurance or state/federally funded program that
11		assumes financial responsibility for medical care provided.
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13	Waiver	The process through which a service organization can be relieved
14		of the billing requirements set out in this policy for particular third
15		party payors.
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18 **RESPONSIBILITIES**

19 The Administrative Agency (AA) must ensure all service providers follow this policy.
 20 Medical service providers and all case management facilities that utilize a fee for
 21 service system of payment with private physicians must follow this policy.

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23

24 **POLICY**

25 All medical care providers and case management facilities must bill third party payors
 26 before charging services to Ryan White and State Services funds for all core medical
 27 care services. Ryan White or State Services monies cannot be used to pay for client
 28 services that can be paid for or charged to any other billable source. Ryan White
 29 cannot be billed for any service where another payor is available.

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32 **PROCEDURE**

33 **Section I. Third Party Payor**

34 Service providers must take the following steps to ensure Ryan White and State
 35 Services funding is the payor of last resort:

- 36
- 37 1. Screen all clients to determine what medical insurance(s) the client possesses (e.g.,
 38 Blue Cross/Blue Shield) and/or what publicly-funded medical benefit program(s) the
 39 client receives.
 - 40 a. If a client does not currently possess any medical insurance but is potentially
 41 eligible, discuss enrollment and next steps for the client. If the client is not
 42 enrolled in an employer-based health insurance because it is cost prohibitive,
 43 discuss the availability of insurance premium and deductible assistance.
 - 44 b. If the client does not receive any publicly funded medical benefit program
 45 (and does not receive nor is potentially eligible for any medical insurance),
 46 assess annual gross individual or family income. If the client appears

- 1 potentially eligible for any programs (e.g., Medicaid, Medicare Part D, CHIP),
2 refer the client to the appropriate office for the application process. When
3 possible, assist the client in this process.
- 4 c. Agencies not already billing third parties should compile a list of all third party
5 payors and potential third party payors found within the client caseload.
6
- 7 2. If the agency is a medical care provider:
8
- 9 a. Prioritize the third party payors identified in 1.c. above and begin pursuing the
10 process to become a provider for those third party payors possessed by the
11 largest number of clients, or with the most potential dollar yield. Each third
12 party payor will require a different application process, and over time, an
13 agency would address all third party payors within their client caseload.
- 14 b. If the agency is found ineligible by a particular third party payor to be a
15 provider for that insurance company or publicly funded medical benefit
16 program, or if becoming a provider for a particular insurance company or
17 publicly funded medical benefit program is not cost effective, the agency can
18 apply for a waiver (see Section III, Waiver).
- 19 c. If the agency receives a waiver to exempt the agency from billing a particular
20 third party payor for medical services received by the client, the agency
21 should explore area medical providers that can bill said third party payor for
22 the medical services rendered, and if appropriate, refer the client there for
23 services.
- 24 d. If the agency receives a waiver to exempt the agency from billing a particular
25 third party payor for medical services received by the client, and no other
26 appropriate medical provider within a reasonable distance can bill that
27 particular provider, the client can continue to receive services through the
28 agency.
- 29
- 30 3. If the agency is a non-medical provider who receives ambulatory/outpatient medical
31 care funds:
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- 33 a. Check with the fee for service contractor or private doctor to determine what
34 publicly funded medical benefit programs and medical insurances they
35 currently accept. Negotiate with the fee for service contractor or private
36 doctor to have them bill the medical insurances or publicly funded medical
37 benefit programs rather than billing Ryan White funds for services rendered.
- 38 b. If the fee for service contractor or private doctor does not currently accept
39 particular medical insurances or publicly funded medical benefit programs
40 found within your client caseload, negotiate with the fee for service contractor
41 or private doctor to have them apply to become a provider.
- 42 c. If the fee for service contractor or private doctor is not amenable to becoming
43 a provider for a particular private medical insurance or publicly funded
44 medical benefit program the agency should attempt to locate a service
45 provider who can bill the said third party payor(s).

- d. If the fee for service contractor or private doctor will not bill nor apply to bill a particular third party payor, and no other appropriate medical service provider is available to bill the said third party payor, the agency may apply for a waiver from billing this third party payor.
- e. The agency can continue to bill Ryan White and/or State Services funds while awaiting a decision on a submitted waiver request. Waiver approval exempts the agency (through the service contractor or private doctor) from billing a *particular* third party payor for medical services received by the client (see Section III, Waiver).

Note: costs incurred from the billing process cannot be charged to the client.

Section II. Client Fee For Service

1. Follow the steps outlined in Section I above to determine if the client has or could have medical insurance and/or receives or is potentially eligible for a publicly funded medical benefit program.
2. Clients must be charged a fee when receiving ambulatory outpatient medical care. Service providers of ambulatory medical care may determine a fee for client without a third party payor through use of a sliding scale, or flat fee system. The fee charged to clients with a billable third party payor will be determined by the third party payor.
3. *Service providers must make a reasonable attempt to collect monies, however services must be provided without regard to the ability of the individual to pay. Monies owed but not received from the client are not considered uncollected debt. Agencies should not track these amounts. Any monies received is considered program income for that month regardless of when services when provided.*
4. Determine annual gross individual or family income for each client with no billable third party payor. This income assessment should be conducted annually, or when client circumstances change. Implement either sliding scale or flat fee system, using this chart for annual maximum allowable out-of-pocket expenses for the client. Out-of-pocket expenses can include over-the-counter medications prescribed by a doctor; co-payments and other non-reimbursed medical costs for family members included in the client’s financial eligibility assessment.

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

- a. Contractors should create a tracking mechanism to ensure individual client charges do not exceed the maximum allowable annual charges.

- 1 b. Example: Client C's income is 150% of the federal poverty level. The agency
2 has chosen the sliding scale system for charging clients. According to their
3 system, Client C is responsible for 2%. As today's visit totaled \$320.00,
4 Client C is asked to contribute \$6.40 to the cost of medical care.
- 5 c. Example: The Westside Agency has a contractual agreement with a local
6 doctor to provide HIV medical care, paying \$100.00 per visit. Client D is a
7 single HIV positive male who has no billable third party payor and income at
8 250% of the federal poverty level. When Westside makes an appointment for
9 Client D to see the HIV physician, or upon receiving confirmation Client D has
10 kept the appointment, Westside charges Client D a flat fee of \$3.00 as a
11 contribution to the cost of medical care provided. Westside continues to pay
12 the doctor the full \$100.00 for Client D's visit. Westside also keeps track of
13 the amount Client D has contributed throughout the year, as this amount
14 cannot exceed 7% of annual gross income.
- 15 d. Example: Client E lives a partner and minor daughter. The family's gross
16 income is \$30,000. The agency has chosen a flat fee system of \$2 for doctor
17 visits. Client E's total medical cost today is \$290.00. Using the flat fee
18 guidelines implemented by the agency, Client E is asked to contribute \$2.00.
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22 **Section III. WAIVER**

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24 Ambulatory outpatient Medical care providers and non-medical care providers receiving
25 ambulatory outpatient medical care funds who cannot meet certain provisions of the
26 payor of last resort policy may apply for a waiver. *A waiver does not release a service
27 provider from the entire Payor of Last Resort policy.*

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29 Reminder: before applying for a waiver, first compile a list of all third party payors and
30 potential third party payors found within the client caseload. Prioritize the third party
31 payors, beginning with those third party payors held by the largest number of clients, or
32 potentially has the highest dollar yield, if billed. Begin the application process to
33 become an eligible provider for each third party payor identified with the client caseload.

34

- 35 1. A service provider may apply for a waiver if:
- 36 a. The service provider is deemed ineligible by a particular third party payor.
37 b. A particular third party payor is held (or potentially eligible for) by less than 10
38 clients or less than 10% of the client caseload.
39 c. The cost of application and billing for a particular third party payor exceeds
40 the annual dollars that could be potentially recovered if the service provider
41 followed through with the application process.
42 d. The service provider is a case management facility that contracts or refers
43 clients to a private doctor or clinic that is not amenable to applying to or billing
44 a particular third party payor.
- 45 2. To initiate a waiver request, the service provider should complete form HIV/STD
46 590.001-A and send it via the Administrative Agency to the appropriate field

1 operations consultant. In the waiver request, the service provider should list each
2 third party payor; for each payor listed, include the reason for the request and all
3 supporting documentation. Verbal requests will not be considered. DSHS will grant
4 waivers for a period of two years, and waivers will require renewal at the end of the
5 two year period.

- 6 3. Service providers may apply for an extension to comply with the third party
7 provision. Extensions will be reviewed on a case-by-case basis.
- 8 4. A waiver does not exempt an agency from pursuing potential medical benefit
9 eligibility for individual clients or from implementing a client fee system.

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13 **DATE OF LAST REVIEW:** June 20, 2007

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15 **REVISIONS:** Due to extensive revision, treated as new policy.