Baltimore City Health Department

Ryan White Office

Ryan White Part A Eligible Metropolitan Areas and Transitional Contract Areas

Assessment Visit

Johns Hopkins Pediatric and Adolescent HIV/AIDS Program

June 1-2, 2009

Program Name/Address:
Johns Hopkins Pediatric and Adolescent HIV/AIDS Program
Intensive Primary Care (IPC) Clinic
200 N. Wolfe Street
Baltimore, Maryland 21231

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Section I: Introduction/Purpose

The Ryan White HIV/AIDS Treatment Modernization Act, the largest Federal program focused exclusively on HIV/AIDS care, addresses the unmet health care needs of persons living with HIV/AIDS by providing primary health care and support services that enhance access to and retention in care. HIV/AIDS disproportionately affects people in poverty, racial/ ethnic populations, and others who are underserved by healthcare and prevention systems. Ryan White–funded programs are the payers of last resort. Ryan White-funded programs are expected to maximize revenue from third party payers and other resources and use Ryan White funds to fill in gaps in care that are not covered by other resources.

The Baltimore City Health Department Ryan White Office (BCHD) engaged Training Resources Network, Inc. (TRN) to conduct an on-site programmatic and fiscal assessment of the Part A Pediatric and Adolescent HIV/AIDS Program of the Johns Hopkins University to determine the extent that resources other than Ryan White Part A funds are being maximized and whether the program could be sustained without Ryan White Part A funds.

Assessment objectives of the on-site fiscal and programmatic assessments included 1) identifying the specific funding stream (insurance or entitlement programs) charged for pediatric outpatient ambulatory health services; 2) delineating the services paid for by the Ryan White Part A program; 3) identifying the insurance or entitlement programs pediatric clients are transitioned to after being processed (paid) through Ryan White Part A; 4) determining the number of new perinatal HIV cases and the number of unduplicated HIV-positive pediatric cases served within the past year; and 5) determining whether other governmental programs provide adequate coverage of the pediatric services for which Ryan White funding is sought. The retrospective review was conducted for March 1, 2008 through February 28, 2009.

Section II: Overview of Johns Hopkins University's Pediatric and Adolescent HIV/AIDS Program

The Pediatric and Adolescent HIV/AIDS Program of the Johns Hopkins University (JHU) provides comprehensive health and social services to infants, children, youth, women and families infected and affected by HIV/AIDS in the interdisciplinary Intensive Primary Care Clinic (IPC). The program serves patients from birth through 24 years of age. The clinical care portion of the program is the Intensive Primary Care Clinic (IPC), which provides intensive services and support using the primary health care and case management. HIV specialty care, including early diagnosis, antiretroviral therapy, OI prophylaxis, monitoring of viral load, CD4 count, medication side effects and clinical disease progression and access to clinical trials is integrated with routine care. Adolescents receive screening and treatment for sexually transmitted diseases and alcohol and substance abuse, reproductive health care including pelvic exams with pap

smears for young women, and contraceptive services such as oral contraceptives, condoms, and Depo-Provera. The interdisciplinary team includes a pediatrician/director, a team of physicians with adolescent medicine and/or pediatric infectious disease expertise, two pediatric nurse practitioners, two nurse case managers, two social workers, a part time psychiatrist, a child life specialist, two outreach workers and a youth advocate. The program links with prenatal care programs, the JHU Moore Clinic for Adults, and the HALO clinic for HIV prenatal care.

Section III: Methodology

The assessment review was conducted at JHU in the IPC. Data was collected through five avenues: 1) Client chart abstractions; 2) Review of billing histories; 3) Review of policies and procedures; 4) Data reports and 5): Staff interviews.

Client Chart Abstraction: The chart abstraction tool was designed to access demographic information regarding age, gender, ethnicity and residence and to determine if household income was paired with the appropriate type of eligible

Reviews of Billing Histories: The services recorded in the medical charts were traced to the billing histories to verify that the services were billed to appropriate third party payers.

Review of Policies and Procedures: The assessment team reviewed position descriptions, policies and procedures for eligibility determination, discharge and/or transitioning/data reports, financial Intake, billing and billing histories.

Staff Interviews: Interviews were conducted with the Part A funded Nurse Medical Case Manager, Social Worker, Director (All Part A funded) and the Clinic Manager.

Data Reports: The assessment team reviewed client level data reports, the Ryan White Annual Data Report (RDR) and reports related to billing.

The 2006 HIV/QUAL Project Sampling Method was used to determine the sample size and to select a random sample. Thirty-three (33) charts were reviewed that focused on services provided in FY 08 (March 1, 2008-February 28, 2009.

Section IV: Results

New Perinatal Cases & Number of Unduplicated Clients

The number of perinatally infected infants was 3.

The number of exposed perinatal infants was 41.

The number of unduplicated HIV-positive pediatric cases 0-12 years was 35.

The number of unduplicated HIV-positive patients age 13-24 years was 164.

The total number of HIV-positive patients was 202.

Client Demographics of Sample

Gender

Gender distribution of client charts reviewed was 21 male clients, 11 female clients and 1 transgender.

Age

The largest proportion of ages from reviewed charts was from 19+ years and lowest was from 3 to 13 years.

Race/Ethnicity

The largest proportion of race/ethnicity of clients from charts was 29 African Americans.

HIV Risk Factor

The most frequent HIV risk factors in the sample were those infected by perinatal transmission.

HIV Risk Factor	Number of Clients
Prenatal Transmission	15
Exposed Infant	3
Infected	0
MSM	9
Heterosexual Contact	5
Undetermined/Unknown	1

Insurance

Client records in the sample indicated that the majority of the clients were enrolled in Medicaid and the next to the largest number did not have any type of insurance.

Insurance	Numbers Enrolled
Medicaid	6
Primary Adult Care (PAC)	2
Other	1

None	23
Not Documented in Chart	1

Terminated during Review Period

1 client in the sample was terminated during FY2008.

Pregnant During Review Period

2 clients in the sample were pregnant during FY2008.

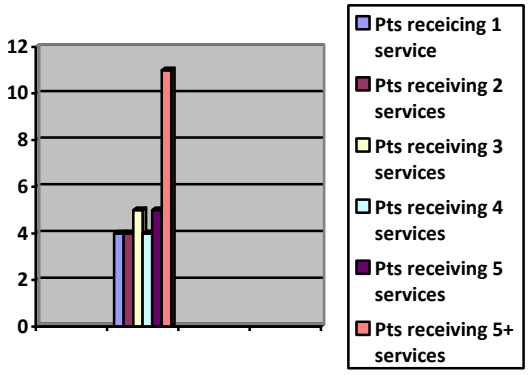
Number of services received during review period

Total number of services provided to patients in sample 142

Average number of services/patient 4.30

Number of Services Provided per Patient

The following table shows the number of services provided per patient.



Number of Patients who moved from Uninsured to Medicaid

9 patients

Billing System

Practice management refers to a set of policies, procedures and practices that enhance efficiency of operations and ensure timely collection of reimbursement. Practice management focuses on the effectiveness of the accounts receivable system, scheduling, office procedures, customer satisfaction and patient flow. The provider's

practice management system, IDX, includes modules for scheduling, billing and reporting.

The clinic is considered a regulated clinic in accordance with the Maryland Department of Health and Mental Hygiene, Health Services Cost Review Commission (HSCRC) Guidelines. Accordingly, all services are identified by Levels of Care within the practice management system and are associated with Relative Value Units (RVUs) and customary charges which approximate actual cost. The customary charges include the professional component (physicians, physician assistants, resident physicians, nurse practitioners). The following table compares the provider's customary charges to reimbursement from Medicaid, the most significant third party payer, for certain services.

Level of Care	RVUs	Customary Charge	Medicaid Reimbursement
Level 1 (0-10 minutes)	2	92.00	86.48
Level 2 (11-25 minutes)	4	184.00	172.96
Level 3 (26-45 minutes)	7	322.00	302.68
Level 4 (46-90 minutes)	15	690.00	648.60
Level 5 (>90 minutes)	18	828.00	778.32

Encounter forms are prepared to document services provided and are the source document for billing. After the service to the patient is completed, the encounter form is reviewed to verify that the service is coded correctly.

JHU actively bills Medicaid, Medicare and other third party payers for services to individuals with HIV/AIDS. Charges and payments from third party payers during the fiscal year ending February 28, 2009 were $768,107 and $721,259, respectively.

IDX uses a nomenclature of numeric codes to identify payers in the billing system. Ryan White is assigned its own payer code so uninsured patients are identified as "Ryan White".

Review of Billing Histories

The assessment team reviewed the March 1, 2008 through February 28, 2009 billing histories for the patients in the sample. Based on this review, the provider actively bills Medicaid and other third party payers. Nearly all the Medicaid billings were paid within one week of services. The billing histories document that the provider follows up promptly on denied claims. There were four rejected claims in the sample, which were all corrected and paid. One claim from February, 2009 was denied because the patient's Medicaid application was pending; as soon as the Medicaid enrollment was completed, five days later, the claim was re-submitted and payment was received promptly.

Also, the assessment team traced the services documented in the medical charts for the patients in the sample to the billing histories. All services recorded in the charts were found in the billing histories.

Funding for the Program

The provider receives funds, as follows:

Ryan White Program	
Part A Medical Case Management	44,975
Part A Mental Health	54,111
Part A Primary Care	110,931
Part B Psychosocial Support	36,652
Part B Oral Health	25,483
Part B Treatment Adherence	111,183
Part D Pediatric	220,524
Part D Youth	197,364
Total Ryan White Program	801,223
State General Funds Enhanced HIV Services	119,482
Philanthropy	15,000
Total	935,705

In addition, JHU provides in-kind support to the clinic, including space costs, the front desk employees, the nurses and medical assistants working in the clinic.

Allocation of Physician's Time

The allocation of physician's time to the Ryan White Part A Primary Care Contract is 18.68% of one physician (George Siberry, MD). In addition, four physicians and one nurse practitioner who are assigned to the clinic are wholly supported by JHU funds.

The assessment team reviewed the data on number of primary care visits to assess the appropriateness of the allocations of physicians' time. During the period March 1, 2008 through February 28, 2009, there were 851 primary care outpatient visits, including 196 services to Ryan White patients (23%). Based on percentage of visits and the support of other practitioners' time from JHU, the allocation of physician's time to the Ryan White Part A Primary Care Contract is appropriate.

Services Supported by the Ryan White Program

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 requires that providers actively pursue appropriate third party reimbursement for services. Specifically, the

legislation requires that providers bill third party payers and participate in the State's Medicaid plan, which requires that providers accept the Medicaid reimbursement as payment in full for the services. That is, the Ryan White Program is the payer of last resort.

In practice, therefore, providers receive Medicaid reimbursement for primary care services defined by the CPT Codes and Ryan White funds for primary care services to uninsured individuals and for services that are not reimbursed by Medicaid. Mental health services are reimbursed by Medicaid if they are provided by a qualified practitioner under the supervision of a psychiatrist and if the patient has a mental health diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Medicaid supports the cost of case management for patients eligible for Rare and Expensive Case Management (REM) Program or Targeted Case Management for HIV-Infected Individuals (TCM). Medicaid does not reimburse for substance abuse services, outreach services and psychosocial services.

Many of the services provided by IPC (nurse case manager and social worker) are not covered by Medicaid, REM or TCM. The social worker and nurse case manager do eligibility determination for Ryan White funding. The social worker does an annual assessment to determine status of insurance as well as social/emotional issues. The staff conducts outreach and home visits when deemed necessary such as evaluating a living situation, checking on the health status of the patient or adherence. Intensive case management services are needed including making referrals to other agencies for assistance with housing, schooling, legal issues, etc. There is a psychiatrist on-site who provides services which are also reimbursable by third parties. In addition, counseling and emotional support is provided often with the staff being the only stable adults in the adolescent's life and therefore providing crisis intervention. The amount of time spent assisting patients with the Medicaid application support is significant. A youth advocate will accompany a client to the Department of Social Services (DSS) to apply for Medicaid and other benefits. The level of follow-up by the social worker and nurse case manager is both impressive and well documented in the charts.

The following table summarizes the services provided by the JHU and the source of funding, as determined by the assessment team:

Description of Services	3rd Party Reimbursement	Ryan White Part A	Other Fund Sources
Primary Care services provided by physicians, physician assistants, nurse practitioners to patients enrolled in Medicaid or other insurance	Yes	No	Yes—JHU
Primary Care services provided by physicians, physician assistants, nurse practitioners to uninsured patients	No	Yes—Primary Care Contract	No
Time spent by physicians, physician assistants, nurse practitioners in consultation with other providers or patient education	No	Yes—Primary Care Contract	Yes—JHU
Clinic costs (front desk staff, medical assistants, office space, telephone, utilities, supplies, etc.)	No	No	Yes—JHU
REM or TCM provided to enrolled beneficiaries	Yes	No	No
Case Management (C. Kiefner and J. Rogers)	No	Yes—Case Management Contract	Not determined
Mental Health services provided by psychiatrists, social workers and other practitioners to patients enrolled in Medicaid or other insurance	Yes	No	Yes—JHU

Description of Services	3rd Party Reimbursement	Ryan White Part A	Other Fund Sources
Mental Health services provided by psychiatrists, social workers and other practitioners to uninsured patients	No	Yes—Mental Health Contract	Not determined

Sliding Fee Scale

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 requires that recipients of Ryan White Part A funds must develop consistent and equitable policies and procedures related to the verification of patients' financial status, implementation of a sliding fee scale. The sliding fee scale must be based on the patient's income and may not entail charging patients whose income is at or below 100 per cent of the federal poverty level (FPL).

The JHU emphasizes eligibility for the various insurances and other benefits that are to be exhausted before Ryan White funds are used. The social worker conducts a financial intake screening on all new patients and a re-screening every six months. The social worker assists patients to apply for Medicaid, Medicare, Maryland Children's Health Program (MCHP) and other benefits. During the period March 1, 2008 through February 28, 2009, the charges to self-pay patients were $24,638. Collections from self-pay patients were $11,386 (46%).

Visits for Initial Diagnosis / Pending Medicaid

The assessment team reviewed the billing histories to identify the number of initial diagnosis visits charged to Ryan White Part A and the number of subsequent visits charged to Ryan White Part A, pending the application for Medicaid. The summary of the results is as follows:

- There were 8 initial diagnosis visits among the sample patients during the period March 1, 2008 through February 28, 2009.
- Two newborns were enrolled in Medicaid at the initial visit.
- Three newborns were enrolled in Medicaid at the second visit.
- One newborn was enrolled in Medicaid at the third visit.
- One newborn was not enrolled in Medicaid after having two visits, occurring in the last two weeks of the review period

- One newborn was not enrolled in Medicaid at the first visit but was transferred to a local pediatrician and did not have any subsequent visits.

Determining Eligibility for Medicaid

The social workers conduct initial interviews and provide assistance with the application for Medicaid. The review of the chart extraction data and the billing histories for the patients in the sample indicate the enrollment in Medicaid improved during the review period, as follows

Type of Insurance	First entry in review period	Last entry in review period
Medicaid	6	11
Primary Adult Care (PAC)	2	6
Other Insurance	1	2
None	23	9
Not documented in chart	1	5

Medical assistance for the increasing population of adolescents and youth has been difficult to acquire. While most of the pediatric patients are eligible for Medicaid as children, they lose coverage at age 19. It is imperative that they obtain Medicaid or the PAC but not so easily done. Both the perinatally acquired and behaviorally acquired adolescents have similar challenges. Undocumented individuals are not eligible for Medicaid. It is difficult to obtain Supplemental Security Income (SSI) for them since having the diagnosis of HIV/AIDS does not automatically make them eligible for SSI. A significant amount of time is demanded of the social worker and nurse case manager supporting the adolescents, helping them to complete the necessary applications, obtaining the necessary documentation and then having the Youth Advocate accompany the adolescent to the DSS for a face-to-face interview. Even when the adolescent receives Medicaid, there is often a lack of follow-up at the 6 month re-enrollment period which sets up an on again/off again enrollment in Medicaid. Barriers to accessing Medicaid for youth include lack of parental support or even availability of a parent (many of whom have died from AIDS), and non-disclosure of the adolescent/young adult's diagnosis to family which makes it difficult to apply for benefits. Youth also suffer from alcohol and substance use, behavioral and mental health issues. Many of these adolescents have raised themselves and have had to be responsible for taking their own medication often at very young ages. Poor health is another deterrent, as are poverty, homelessness and hopelessness. Despite these challenges the social worker and nurse case manager make every effort to reduce these barriers and enroll them in Medicaid or determine eligibility for Ryan White Services.

They also employ a Youth Advocate and JHU student volunteers who assist in the completion of insurance applications. An additional support is the assistance of a lawyer who is funded through a private foundation contract to aid those with denial for disability insurance or assistance with landlord/disputes.

Section V: Strengths of the Johns Hopkins University's Pediatric and Adolescent HIV/AIDS Program

- Youth advocate accompanies the adolescents to DSS to ensure that they apply for Medicaid and MCHP. This is needed due to many barriers that adolescents face including lack of available parents.

- The social worker and the Case Manager have been successful in ensuring that patients are enrolled in Medicaid, MCHIP and other entitlements. The system of enrolling patients in Medicaid is impressive including frequent social worker and Nurse Case Management documentation in charts of status of patient's application for Medicaid and meeting appointments. Such documentation and oversight reduce the number of patients falling between the cracks.

- The IPC refers clients to attorney, funded by a private foundation, to assist in removing barriers to care and access to services.

- There is excellent oversight of the transition process of adolescents and young adults to adult care and insurance. The social worker accompanies adolescents to visit the adult clinics and monitors them up to 12 months in adult service.

- There is excellent follow-up of patients including home visits, referrals and follow-up calls.

- The provider is able to draw on other resources and is not solely dependent on federal contract funds. The organization's diversification of resources supporting the HIV/AIDS services allows the provider to enrich the programs supported by public funds and insulate the services from cash flow problems, unanticipated expenses or economic downturns.

- The provider has strong practice management, including electronic billing, pre-visit and pre-billing activities, which tend to enhance billing and collections. The designation as an HSCRC regulated clinic is favorable because it allows the program to maximize reimbursement from Medicaid and other third party payers.

Section VI: Fiscal Findings and Recommendations

F1. Finding (Best Practice): The provider does not monitor data on a regular basis to confirm the appropriateness of the allocations of time and effort.

F1. Recommendation: The provider should review data on number of patients, number of visits and RVUs to confirm the appropriateness of the allocations of time and effort at least annually.

Section VII: Program Findings and Recommendations

P1. Finding (Program Expectation): The assessment team noted that there was no attestation from the patients reporting 0 in income.

P1. Recommendation: The provider should develop a form for the patient to sign, attesting that he/she has no income.