

**Virginia Bleeding Disorders Program
Pool of Funds Guidelines
Division of Child and Adolescent Health
Virginia Department of Health**

Introduction

The Virginia Bleeding Disorders Program provides a limited amount of money to assist Virginia's uninsured and underinsured persons children with inherited bleeding disorders receive care they otherwise could not afford. The Virginia Bleeding Disorders Program (VBDP) receives Title V funds from the federal Maternal and Child Health Block Grant and state general funds. This is not an entitlement program. The following guidelines have been developed to allocate the funds to the children with the greatest financial need.

Covered Conditions

Persons with inherited bleeding disorders are those who have hemophilia or von Willebrand Disease.

Covered Services

Covered services under Pool of Funds distribution are services that are medically necessary for the treatment and monitoring of the inherited bleeding disorder in consultation with the hemophilia treatment center (HTC). They include the following:

1. Comprehensive clinic services provided by a core team consisting of a hematologist, social worker, nurse and physical therapist.
2. Medications related to the treatment of bleeding disorders.
3. Hospitalization for severe, emergent bleeding episodes; preauthorized hospitalizations related to the bleeding disorder. Required orthopedic surgery is limited to individuals up to 21 years of age. Emergency room care is covered for acute bleeding episodes.
4. Ancillary services such as orthopedic appliances (up to age 21 years), imaging studies, physical therapy and laboratory tests related to the bleeding disorder.

Restricted services that may be covered but must be preauthorized by a review panel:

1. Immune tolerance therapy
2. Primary prophylactic treatment
3. Secondary prophylactic treatment of more than one month's duration
4. Elective surgery that has an impact on future bleeding or joint outcome

For a restricted service to be preauthorized:

1. The referring HTC must submit the preauthorization request form with appropriate documentation to the VBDP Program;
2. VBDP will convene a review panel consisting of a physician, a social worker and a nurse from a federally funded HTC in VA that is not currently providing care to the patient.
3. If the review panel recommends the use of VBDP Pool of Funds, the reviewed services will be charged to the program through contracted vendors.
4. If the review panel denies the use of VBDP Pool of Funds, the patient may appeal as delineated later in this guidance.

Noncovered Services

Services that are not covered because of limited funds include:

1. Insurance deductibles and/or copayments
2. Experimental or investigative medical and surgical treatment or procedures
3. Dental services
4. Ambulance or other transportation services
5. Wheelchairs and their repairs

Genetic services that are funded through a different mechanism are not included in the VBDP Pool of Funds.

Eligibility Requirements

Patients must meet all of the following requirements to obtain funds from the Pool of Funds.

• **Residency Requirements**

Use of the Pool of Funds is based on the residence of the child. Eligible children must be Virginia residents with proof of residency. A post office box in Virginia does not establish residency. Examples of verification of residency are Virginia motor vehicle registration,

Virginia driver's license, proof of payment of Virginia state income taxes, proof of enrollment in a local school, or a lease or utility bill in the name of the applicant or child's parent/legal guardian. The regional pool of funds used is based on the child's place of residence.

- **Financial Requirements**

The Pool of Funds program is designed for families with gross family income at or below 200% (233% in Northern Virginia) of the Federal Poverty Level (FPL) based on the Virginia Department of Health's Regulations Governing Financial Eligibility for Services (12 VAC 5-200). Patients with incomes above 200% FPL may receive services from the Pool of Funds after meeting spenddown. Once the family has incurred or been billed for medical services equal to 5.0% of their gross annual income for medical bills of the program patient(s) during the twelve month period from the date of admission to the program, the Pool of Funds may be accessed for covered services. Due to the extremely high cost of hemophilia medications, patients with inherited bleeding disorders may pay the annual medical spenddown in monthly installments to the program coordinator. The spenddown must be fully paid by the end of the 12-month period from the annual recertification date.

- **Health Insurance**

The Pool of Funds covers persons without health insurance, persons with health insurance that may not cover all of their medical expenses (underinsured), and persons on a pre-existing condition clause of their insurance. The Pool of Funds, however, is considered the payer of last resort. Therefore, all attempts to obtain health insurance will be made by the patient and family in conjunction with the Virginia Bleeding Disorders Program before the patient is eligible for Pool of Funds.

For persons with no health insurance, the patient must be screened for state and federal medical assistance programs including FAMIS, FAMIS Plus, and Supplemental Security Income, if indicated. Persons with no health insurance must be screened for, and if warranted complete all necessary applications and requirements for Patient Services, Incorporated assistance in procuring or maintaining health insurance coverage.

Limitations of the Pool of Funds

The Pool of Funds consists of a limited amount of grant funds that may be replenished annually. The Center reserves the right to deny access to the Pool of Funds for an otherwise eligible patient if the funds are depleted.

Policies and Procedures

1. The patient shall be deemed eligible for the Pool of Funds once:
 - a. The patient/family has completed a financial and insurance eligibility application;
 - b. The VBDP has determined that the patient/family has exhausted insurance and other sources of payment for the patient's care; and
 - c. The VBDP has approved the application and services.
2. Authorization by the VBDP shall be required **PRIOR** to the commencement of all covered services. Preauthorization shall not be required whenever a patient, **who is enrolled as a participant in the VBDP Pool of Funds**, requires emergency hospitalization for an acute bleeding episode. The patient/family must notify the VBDP within seven (7) calendar days of the hospital admission.
4. Payment for retrospective services shall **NOT** be approved.
5. Emergent services can be initiated without full completion of the application process at the Manager of the VBDP's discretion. If the patient is found not eligible, the urgent/emergent treatment service shall be paid from the Pool of Funds, but the patient/family is to be notified that the VBDP shall not authorize future services until there is a change in their eligibility status.
6. Services shall be obtained from a vendor with a contract with the VBDP/VDH who has credentials and licensure to provide the needed services and who agrees to accept the payment as payment in full and not to pursue balances from the child's family.
8. Verification, i.e., hospital discharge summary and report of services, of the patient's receipt of the authorized service shall be completed and documented before the vendor is paid.
9. Reimbursement to the vendor shall be no more than at the Medicaid fee-for-service rate of reimbursement for the specific service.
10. The Pool of Funds shall be documented payer of the last resort.
11. Use of the Pool of Funds shall be limited annually to \$50,000 per patient. Extraordinary circumstances may warrant an exception to this limit and must be appealed to the VBDP Review Panel.
12. The VBDP will review the policies and procedures at least every six months.

VBDP Review Panel

If a request for the use of Pool of Funds is denied, the patient/family or the referring HTC may ask for the decision to be reviewed by the VBDP Review Panel. The panel consists of a physician, nurse and social worker from a federally funded HTC in Virginia that is not currently providing medical care to the patient. Pre-service reviews will receive written notification of response within thirty days after receipt of request. Post-service reviews will receive written notification of response within sixty days after receipt of request. Emergency reviews must be submitted within 48 hours of the precipitating event.

Appeal Process

If a request for assistance from the Pool of Funds is denied and the VBDP review process is exhausted, the family may appeal the decision in writing to the Director of the Children with Special Health Care Needs Program at the Virginia Department of Health (VDH). Advice may be sought from the VDH Adjudication Officer in the Office of Family Health Services in cases where it is deemed necessary. The Adjudication Officer's decision is final and binding.