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# Health Center Compliance Manual
# Webinar #2:
# Making Care Affordable While Maximizing Reimbursement: Sliding Fee Discount Program and Billing & Collection (Chapters 9 & 16)

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*This webinar series is co-sponsored by the National Association of Community Health Centers (NACHC)*

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# PRESENTER: MARCIE ZAKHEIM

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- Counsel to National Association of Community Health Centers, and numerous Primary Care Associations and health centers nationwide for over 20 years
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# AGENDA

- **A Quick Refresher: Introduction to Health Center Program Compliance Manual and Site Visit Protocol**
- **Sliding Fee Discount Program**

  Program Requirement 7 → Chapter 9
- **Billing and Collections**

  Program Requirement 13 → Chapters 16

# COMPLIANCE MANUAL

- August 28, 2017: HRSA issued the final Health Center Program Compliance Manual – was effective immediately
- Separate chapters for each requirement
  - Legal authority – statutory/regulatory citations
  - Requirements – statutory/regulatory requirements
  - Demonstrating compliance – how health centers can demonstrate compliance with the requirements – must meet all elements
  - Related Considerations – areas for which health center retains discretion in making decisions on how to implement compliance elements – not within BPHC's purview to assess compliance
- Aligns credentialing/privileging requirements and the quality improvement/assurance requirements with the FTCA deeming requirements for the same areas

# COMPLIANCE MANUAL

- Serves as consolidated resource and definitive guidance for interpreting Program Requirements and FTCA requirements
- Supersedes many current PINs / PALs (including SFDP, governance and budgeting/accounting), and "summary of health center program requirements"
- Deletes "Scope of Project" as a separate requirement – 18 requirements now
- Will not supersede
  - Scope guidance
  - Service area overlap policy (PIN 2007-09)
  - Emergency management program expectations (PIN 2007-15)
  - FTCA Manual and deeming PALs
  - UDS Manual and resources

# COMPLIANCE MANUAL

- Applies only to activities included in the health center's scope of project
- Does not provide guidance on requirements in areas beyond HRSA purview (such as 340B, Medicaid, Medicare)
- Pay attention to the Related Considerations section – reflects implementation areas that HRSA explicitly delegated to health center discretion (important when talking with reviewers!)
- Webpage:
  - Compliance Manual
  - Frequently Asked Questions
  - Responses to Comments received by HRSA

https://www.bphc.hrsa.gov/programrequirements/compliancemanual/index.html

# COMPLIANCE MANUAL: PROGRAM REQUIREMENTS COMPARISON

| # | Site Visit Guide (FY 2015) | # | Compliance Manual |
|---|---|---|---|
| | | 1 | **Health Center Program Eligibility** |
| | | 2 | **Health Center Program Oversight** |
| 1 | Needs Assessment | 3 | Needs Assessment |
| 2 | Required and Additional Services | 4 | Required and Additional Services |
| 3 | Staffing | 5 | **Clinical** Staffing |
| 4 | Accessible Hours of Operation/Locations | 6 | Accessible Locations and Hours of Operation |
| 5 | After Hours Coverage | 7 | Coverage for **Medical Emergencies During and** After Hours |
| 6 | Hospital Admitting Privileges and Continuum of Care | 8 | **Continuity of Care** and Hospital Admitting |
| 7 | Sliding Fee Discounts | 9 | Sliding Fee Discount **Program** |
| 8 | Quality Improvement/ Assurance Plan | 10 | Quality Improvement/ Assurance |
| 9 | Key Management Staff | 11 | Key Management Staff |
| 10 | Contractual / Affiliation Agreements | 12 | Contracts and **Subawards** |

| # | Site Visit Guide (FY 2015) | # | Compliance Manual |
|---|---|---|---|
| | | 13 | **Conflict of Interest (moved from #19)** |
| 11 | Collaborative Relationships | 14 | Collaborative Relationships |
| 12 | Financial Management and Control Policies | 15 | Financial Management and **Accounting** Systems |
| 13 | Billing and Collections | 16 | Billing and Collections |
| 14 | Budget | 17 | Budget |
| 15 | Program Data Reporting Systems | 18 | Program **Monitoring** and Data Reporting Systems |
| 16 | **Scope of Project** | NA | **(Incorporated into other requirements, as appropriate)** |
| 17 | Board Authority | 19 | Board Authority |
| 18 | Board Composition | 20 | Board Composition |
| 19 | **Conflict of Interest Policy** | | **(Moved to #13)** |
| | | 21 | **Federal Tort Claims Act (FTCA) Deeming Requirements** |

# SITE VISIT PROTOCOL

- Site Visit Guide was replaced by a new Site Visit Protocol (SVP), which is aligned with the Health Center Program Compliance Manual
  - Issued early January – effective for Operational Site Visits, New Grantee Site Visits and FQHC Look-Like Designation Site Visits on or after January 22, 2018
  - More proscriptive on reviewers than prior Site Visit Guides – see below
- For each Chapter, the following are identified
  - Statutory and regulatory authority (consistent with the Manual)
  - Primary and secondary reviewers

# SITE VISIT PROTOCOL

- For each Chapter, the following are identified (cont.)
  - Documents lists: (1) documents sent prior to site visit; and (2) documents provided on-site – NO OTHER DOCUMENTS SHOULD BE REQUESTED
  - Which "Demonstrating Compliance" elements from the Manual will be assessed off-site by HRSA and which will be assessed on-site by review team
  - Assessment methodology (policy/procedure review, samples of files and records, interviews, site tours) that should be used by the reviewers to determine compliance with each on-site element
  - Questions to determine site visit findings

https://www.bphc.hrsa.gov/programrequirements/svguide.html

# IMPACT ON OPERATIONAL SITE VISITS

- OSV is still a 3 day on-site audit of a health center's compliance with the requirements of the Compliance Manual
  - Three reviewers (admin/governance, clinical, financial) who are consultants acting as "authorized representatives of HRSA"
  - Either project officer or another person from HRSA operations divisions will be on site
  - Elements of on-site process unchanged from prior process – entrance conference, facility visits, document reviews, interviews and exit conference
  - Should be able to make minor revisions to policies (if board is available to approve) and procedures while review team is on site – no revisions after they leave!

# IMPACT ON OPERATIONAL SITE VISITS

- Reviews should be more objective
  - Has the center established and implemented required policies, procedures, etc. that include all elements/bullets for "Demonstrating Compliance" sections of Manual and SVP?
  - SVP is more proscriptive with respect to review process (documents, review methodologies)
  - Greater level of focus on health center implementation – not just compliance on paper – review of sample charts and records to assess implementation
  - Assessment should not discuss whether the reviewer thinks what you have in place is "good" or "bad"

# IMPACT ON OPERATIONAL SITE VISITS

- Final reports should be issued by HRSA within 45 days of the site visit
  - Before finalizing the reports, HRSA will review the findings and may adjust the reports accordingly
  - Report will include findings and final compliance determinations
  - Non-compliance will result in grant conditions
  - Report will also be used by FTCA to support deeming decisions and identify TA needs – but no conditions on FTCA elements that are not also part of program requirements (credentialing and privileging, QI/A)

# CHAPTER 9: SLIDING FEE DISCOUNT PROGRAM

- What are the Authorities?
  - *Section 330(k)(3)(G) of the PHS Act; 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u)*
- What are the Requirements?
  - Must operate in a manner that ensures that no patient is denied service due to an individual's inability to pay
  - Must prepare a schedule of fees or payments for the provision of its services (1) consistent with locally prevailing rates or charges and (2) designed to cover its reasonable costs of operation (BUT – compliance with this requirement is addressed under Billing and Collection)
  - Must prepare a corresponding schedule of discounts (sliding fee discount schedule or SFDS) to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay

# CHAPTER 9: SLIDING FEE DISCOUNT PROGRAM

- What are the Requirements? (cont.)
  - Must establish systems for sliding fee eligibility determination
  - Schedule of discounts must provide for:
    - A full discount to individuals and families with annual incomes at or below 100% of the most recent Federal Poverty Guidelines (FPG); can collect nominal charges for services provided to such individuals and families where imposition of such fees is consistent with project goals; and
    - No discount to individuals and families with annual incomes greater than 200% of the FPG

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Many of the details included in PIN 2014-02 were not included in Guide
- Must have sliding fee discount schedule(s) reflecting current Federal Poverty Guidelines (FPG)

## Compliance Manual: Chapter 9

- PIN 2014-02 superseded and elements incorporated into Chapter 9 and Chapter 16 – if it's not in the Manual, it's not required!
- Must incorporate the most recent FPG
  - **SVP Element e**: Incorporation of Current Federal Poverty Guidelines
    - Paper assessment – review all Sliding Fee Discount Schedules for income ranges and family size, and compare to latest FPG

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Must adjust fees for individuals / families with annual incomes above 100% and at or below 200% FPG and have at least three discount pay classes

## Compliance Manual: Chapter 9

- Retains general sliding fee discount schedule structure requirements
  - At least 3 discount pay classes adjusted based on "gradations in income levels"
- Can have multiple discount schedules based on services (broad service types or distinct subcategories) and/or delivery methods – no other factors!
- Explicit discretion – how many levels above 3 (if any); income ranges per level; method of discount (e.g., flat fee or %)

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element c**: Sliding Fee for Column I Services
  - Paper assessment of whether SFDS(s) for direct services provide
    - Discounts consistent with the requirements (at least 3 pay classes based on gradations of income)
    - No discounts for patients above 200% FPG unless the health center has another source of funding (such as other grants) to support such discounts
- **SVP Element d**: Multiple Sliding Fee Discount Schedules
  - Paper assessment of each SFDS and basis for separate schedules to ensure that each SFDS is
    - Based either on service or service delivery method; AND
    - Not based on other factors (such as site location, insurance status, demographics of patients)

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Must offer full discount for individuals / families with annual incomes at or below 100% FPG unless center has elected to have nominal charge
  - Nominal from perspective of patient
  - Fixed fee that does not reflect true cost of service
  - Not more than fee paid by patient in first discount pay class above 100%

## Compliance Manual: Chapter 9

- Retains general nominal fee structure requirements
  - Explicit discretion on whether to establish nominal charge
- Adds specific regulatory requirement that nominal charges may be collected only where "imposition of such fees is consistent with project goals"

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element c**: Sliding Fee for Column I Services
  - Paper assessment of whether SFDS(s) for direct services provides
    - Full discount or no more than nominal charge for patients at or below 100%
    - Nominal charge that is less than fee paid by patient in first sliding fee pay class above 100%
- **SVP Element b**: Sliding Fee Discount Program Policies
  - Interview board members and key management staff
  - Review policies and documentation of board involvement in setting nominal fee (unless board-approved policy states a specific fee)
  - Assess whether the nominal fee is a flat fee that is nominal from the patient's perspective and not based on actual cost of the service

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Must apply to all in-scope services for which there is an established charge, regardless of service type or mode of delivery
  - Services provided by contracts and referrals must be discounted in accordance with same structural criteria for direct services (referrals can offer greater discount)
  - Must be included in written agreements

## Compliance Manual: Chapter 9

- Retains requirement to apply to all in-scope services and the specific requirements for services provided by contracts and referrals
  - NOTE: health center is not prohibited from subsidizing cost of care; referral provider may be able to use its own charity care policy if discounts apply equally to all eligible individuals and MOU includes language indicating that the policy complies with Section 330 requirements and has been reviewed and approved by the health center

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element a**: Applicability to In-Scope Services
  - Policy review and interview staff involved in implementing SFDP
  - Assess whether all in-scope services are available under center's SFDS or other discounts (such as referral provider's discount program) – specific structure of discounts assessed under other elements
- **SVP Element i**: Sliding Fee for Column II Services
  - Document review: required services provided only by contract – review all contracts; additional services provided only by contract – review up to 3 contracts; required and additional services provided direct and by contract – review 2-4 contracts
  - Interview staff that administers contracts
  - Assess whether discounts available to patients receiving services through contracts meet all discount requirements ("such as" health center bills patients based on its discount schedule or contract includes specific sliding fee provisions – but not necessarily both)

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element j**: Sliding Fee for Column III Services
  - Document review: required services provided only by referral – review all referrals; additional services provided only by referral – review up to 3 referrals; required and additional services provided direct and by referral – review 2-4 referrals
  - Interview staff that administers referral arrangements
  - Assess whether discounts available to patients receiving services through referrals meet all discount requirements or offer greater discounts

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Must assess all patients for eligibility based on income and family size, unless patient declines / refuses to be assessed

## Compliance Manual: Chapter 9

- Must have operating procedures for assessment / re-assessment, consistent with board-approved policy, and records that it occurred (except when patient has declined/refused)
- Explicit discretion to determine
  - Whether to permit self-declaration
  - How to treat patients who refuse
  - How and with what frequency to re-assess
  - How to document income and family size
  - Whether to take into consideration patient population characteristics when developing assessment procedures

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element f**: Procedures for Assessing Income and Family Size
  - Policy review and interview board members, key management staff, staff involved in implementing the SFDP and additional staff such as outreach, front desk, billing, etc.
  - Assess whether the center has operating procedures for assessment/re-assessment of all patients for income and family size, consistent with the board-approved policies for the SFDP
- **SVP Element g**: Assessing and Documenting Income and Family Size
  - "Hands-on" assessment – review sample of 5-10 records, files or other forms of documentation of patient income and family size, including both insured and uninsured patients
  - Determine whether consistent assessment/re-assessment occurs based on the sample

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- If patient is insured and eligible for discounts, must be charged no more than amount they would owe under their SFDS pay class, subject to legal or contractual limitations

## Compliance Manual: Chapter 9

- Retains requirement to discount cost-sharing for insured patients – clarifies that it applies to "any out of pocket costs" – deductibles and co-payments
  - **SVP Element k**: Applicability to Patients with Third Party Coverage
    - Policy review and interview board members, key management staff, staff involved in implementing the SFDP and other applicable staff
    - Determine whether insured patients eligible for SFDS are charged no more than amount owed under pay class

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Must have written board-approved policies and supporting procedures addressing the following areas
  - Definitions of income and family

## Compliance Manual: Chapter 9

- Board-approved policies include
  - Definitions of income and family – income defined as earnings over a given period of time used to support the patient/household based on criteria of inclusions and exclusions – does not include assets
  - Explicit discretion to determine whether to take into consideration patient population characteristics when developing definitions

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Board-approved policies and supporting procedures (cont.)
  - Eligibility for discounts based only on income and family size for all patients
  - Documentation and verification requirements and frequency of re-evaluation
  - Specific structure of all discount schedules

## Compliance Manual: Chapter 9

- Board-approved policies (cont.)
  - Assessment of all patients based only on income and family size and methods for conducting assessments
  - Does not address including documentation / verification requirements
  - Retains requirement to include specific structure of schedules
  - Adds election of nominal fee (if applicable) and definition

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element b**: Sliding Fee Discount Program Policies
  - Interview board members and key management staff
  - Assess whether the board-approved policies are applied uniformly to all patients and include all required elements
  - In assessing the structure of the SFDS(s), review to ensure that charges are adjusted based on ability to pay, such as flat fees that differ across the pay classes or graduated % of charges

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Board-approved policies and supporting procedures (cont.)
  - Methods to make patients aware of availability of discounts – appropriate languages and literacy levels

## Compliance Manual: Chapter 9

- Health center must have mechanisms to inform patients about availability of discounts in appropriate languages and literacy levels
  - Does not specify that it needs to be in board-approved policy – but best practice
  - Examples – information at intake and publishing information on website
  - Explicit discretion to determine how to inform patients about discounts

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element h**: Informing Patients of Sliding Fee Discounts
  - "Hands-on" assessment – conduct site tour, interview staff and review mechanisms for informing patients to determine whether there are mechanisms in place for informing patients of the availability of SFDP and how to apply for it

# SLIDING FEE DISCOUNT PROGRAM

## Site Visit Guide: Program Requirement #7

- Must evaluate the sliding fee discount program in its entirety at least once every three years from perspective of reducing financial barriers to care

## Compliance Manual: Chapter 9

- Retains evaluation requirement – includes minimum elements
  - Collection of utilization data
  - Use of such data (and other applicable data, such as patient satisfaction survey results) to evaluate the effectiveness
  - Identify and implement changes as necessary
- This does not supersede requirement to review/revise annually in accordance with new poverty guidelines

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element l**: Evaluation of the Sliding Fee Discount Program
  - Policy review, interview board members, key management staff, staff involved in implementing the SFDP and other applicable staff AND review data, reports and relevant materials used by the health center to conduct evaluation of SFDP
  - Assess whether the center collects and utilizes data to assess at least once every 3 years whether patients in each pay class are accessing care (i.e., the effectiveness of SFDP in reducing financial barriers to care)
  - Assess whether the health center took follow-up actions as a result of evaluations, as necessary

# SLIDING FEE DISCOUNT PROGRAM

- Discussion of the following areas from PIN 2014-02 are included under Billing and Collection (Chapter 16)
  - Waiver or reduction of fees due to inability to pay, including specific circumstances
  - Additional billing options / payment methods to help patients pay, such as grace periods, payment plans, cash incentives (OPTIONAL)
  - Discharge of patients or limitation of services for refusal to pay (OPTIONAL)
  - Charges for supplies and equipment related to but not included in the service (such as dentures, crowns, eye glasses) (OPTIONAL)
  - Provision of greater discounts than what are available under the SFDP if health center has another funding source to subsidize such discounts (OPTIONAL)

# CHAPTER 16: BILLING AND COLLECTION

- What are the Authorities?
  - *Section 330(k)(3)(E), (F), and (G) of the PHS Act; and 42 CFR 51c.303(e), (f), and (g) and 42 CFR 56.303(e), (f), and (g)*
- What are the Requirements?
  - Must prepare a schedule of fees (chargemaster) for the provision of its services (1) consistent with locally prevailing rates or charges and (2) designed to cover its reasonable costs of operation
  - Must assure that any fees or payments required by the center for health care services will be reduced or waived in order to assure that no patient will be denied such services due to an individual's inability to pay for such services
  - Must establish systems for eligibility determination and for billing and collections with respect to third party payors
    - REMINDER: eligibility for sliding fee is included under Chapter 9

# CHAPTER 16: BILLING AND COLLECTION

- What are the Requirements? (cont.)
  - Must make every reasonable effort to enter into contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:
    - A State Medicaid plan approved under title XIX of the Social Security Act (SSA) [42 U.S.C.1396, et seq.] for the payment of all or a part of the center's costs in providing health services to persons who are eligible for such assistance; and
    - The Children's Health Insurance Program (CHIP) under title XXI of the SSA [42 U.S.C. 1397aa, et seq.] with respect to individuals who are State CHIP beneficiaries

# CHAPTER 16: BILLING AND COLLECTION

- What are the Requirements? (cont.)
  - Must make and continue to make every reasonable effort to collect appropriate reimbursement for its costs on the basis of the full amount of fees and payments for health center services without application of any discount when providing health services to persons who are entitled to:
    - Medicare coverage under title XVIII of the SSA [42 U.S.C. 1395 et seq.];
    - Medicaid coverage under a State plan approved under title XIX of the SSA [42 U.S.C.1396 et seq.]; or
    - Assistance for medical expenses under any other public assistance program (for example, CHIP), grant program, or private health insurance or benefit program.
  - Must make and continue to make every reasonable effort to secure payment for services from patients, in accordance with health center fee schedules and the corresponding schedule of discounts

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Board required to approve fee schedule

## Compliance Manual: Chapter 16

- Includes fee schedule requirements consistent with statute and regulation
  - Must prepare a schedule of fees for all in-scope services that are typically billed for in local health care market
  - Two factors used to develop and update the fee schedule – data on locally prevailing rates / charges and actual reasonable costs of operation
  - Explicit discretion to determine how to consider each of the two factors and what data should be used to determine locally prevailing rates
  - Board-approval no longer required

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Board required to approve fee schedule

## Compliance Manual: Chapter 16

- Explicit discretion to determine whether to charge a single fee for related services, medically necessary supplies and/or equipment – examples
  - Single fee for immunizations provided at a well-child visit
  - Bundling services that require multiple visits into single fee (such as prenatal care)

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element a**: Fee Schedule for In-Scope Services and **SVP Element b**: Basis for Fee Schedule
  - Review fee schedule and compare to Form 5A, review most recent data and documentation of analyses used to set fees
  - Assess whether the fee schedule applies to all in-scope services typically billed in local health care market
  - Assess whether the health center utilized data on locally prevailing rates and costs to develop fee schedule

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Must have systems in place to make reasonable efforts to collect and receive reimbursement for costs of providing services
  - Participate in Medicaid and CHIP
  - Make reasonable efforts to collect from Medicare, Medicaid, CHIP, other insurance without application of discounts

## Compliance Manual: Chapter 16

- Requires participation in Medicaid, CHIP, Medicare and, as appropriate other payors –
  - Explicit discretion on whether to participate in any specific insurance plan
  - **SVP Element c**: Participation in Insurance Programs
    - Review list of provider and program/site billing numbers and documentation of participation in plans
    - Assess participation in Medicaid, Medicare, CHIP AND other plans (and justification required if not participating in other plans – but what about discretion??)

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Must make reasonable efforts to secure payment from patients for amounts due in a manner that does not create barrier to care
- Must have written board approved policies and supporting procedures for billing and collections – general statement without much detail (other than waiver of charges)
- Expectation to assist patients in enrolling in coverage programs

## Compliance Manual: Chapter 16

- Must have systems which may include operating procedures to
  - Educate patients about insurance and related coverage
  - Bill 3rd payors in timely manner
  - Request applicable payments from patients while ensuring no patient is denied service due to inability to pay
- Must have
  - Billing records that document timely and accurate billing of 3rd party payors
  - Billing records or other documentation that patients are charged consistent with fee and discount schedules and reasonable efforts are made to collect

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element d**: Systems and Procedures
  - Interview staff involved in educating patients on insurance options and billing and collection
  - Review eligibility, education and enrollment procedures, billing systems and contracts with outside organizations that conduct billing and collection on behalf of the center
  - Health center must provide at least one example of how the center educates patients on availability of insurance
  - Assess whether the center has systems in place for billing third party payors and for collecting balances from patients in a manner that ensures no one is denied service due to inability to pay

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element f**: Timely and Accurate Third Party Billing
  - Interview staff and review collection rates by payor and billing procedures
  - Assess whether claims are submitted within 30 days of the service and whether claims rejected for inaccuracy are corrected and re-submitted
- **SVP Element g**: Accurate Patient Billing
  - Mostly (but not exclusively) paper and "hands-on" assessment – fee schedule, SFDS, sample of billing and payment records for self-pay patients, billing and collection systems and procedures
  - Assess whether patients are billed in accordance with fee schedule and whether correct discounts are applied
  - Assess whether and how center attempts to collect amounts owed by patients, including discounted and nominal fees

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Must have Board-approved policies and supporting procedures to waive or reduce charges that identify circumstances with specified criteria for when charges will be waived and specific health center staff with authority to waive

## Compliance Manual: Chapter 16

- Retains requirement to have board-approved policies and supporting procedures to waive or reduce charges "due to inability to pay"
  - Must include specific circumstances to trigger waiver/reduction
  - Does not require that the policy include which staff are authorized to approve waiver

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element h**: Policies and Procedures for Waiving or Reducing Fees
  - Paper and "hands-on" assessment – review policies and procedures, as well as sample of 2-3 billing records where patient fees were waived or reduced
  - Assess whether the center has a policy/procedure that addresses specific circumstances or criteria related to inability to pay (regardless of income level) to ensure appropriate waiver/reduction
  - Assess whether the center follows this policy/procedure

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Discussion of board-approved systems like grace periods, payment plans, etc., to assist patients in paying addressed only in PIN 2014-02

## Compliance Manual: Chapter 16

- Health centers "may" establish optional systems to help patients pay, like grace periods, payment plans, cash incentives
  - Must have operating procedures if these options are selected
  - Must be accessible to all patients regardless of income level or sliding fee discount pay class

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element e**: Procedures for Additional Billing or Payment Options
  - Assess whether center offers additional billing options or payment methods
  - If so, what are those options, are there operating procedures for implementation and are they accessible to all patients regardless of income level or SFDS pay class?

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Can use non-Section 330 funds to subsidize discounts for specific services provided to individuals not eligible for SFDP (i.e., patients above 200% FPG) consistent with the terms and conditions of such funding sources – was addressed only in PIN 2014-02

## Compliance Manual: Chapter 16

- Explicit discretion to support discounts greater than those available under the SFDP if the health center has non-330 funding source to subsidize / cover all or part of fees for certain services provided to specific patients, consistent with terms and conditions of such source,
  - Presumption that this is available to support discounts for individuals not eligible for SFDP (i.e., patients above 200% FPG), as well as deeper discounts for SFDP-eligible individuals

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Supplies and equipment addressed only in PIN 2014-02, which required (1) structure of charges to be based on analyses of patient needs and support patient access; (2) inclusion of provisions to waive/reduce payments; and (3) information to patients regarding amount of out of pocket costs and what payment plans are available (if any)

## Compliance Manual: Chapter 16

- If center provides supplies and equipment related to but not included in service as part of prevailing standard of care and charges for these items, must inform patients of out of pocket costs prior to time of service
  - Does not mention provisions to waive/reduce payments (implied by requirement to have waiver/reduction policy and procedures)
  - Explicit discretion to determine how to charge for medically-related supplies and equipment
  - **SVP Element i**: Billing for Supplies and Equipment – focuses on whether patients are notified about out of pocket costs in advance of services – NOT on how center charges for such items

# BILLING AND COLLECTIONS

## Site Visit Guide: Program Requirement #13

- Optional system for discharging patients for refusal to pay – board-approved policy that
  - Defines "refusal to pay
  - Specifies what individual circumstances are to be considered in making determination
  - What collection efforts/enforcement steps are to be taken prior to discharge

## Compliance Manual: Chapter 16

- Still optional but the policy applies to limiting services as well as discharge
  - Must distinguish between inability to pay and refusal to pay
  - Must require patient notification of: (1) amounts owed to the health center; (2) how much time the patient has to pay; (3) specific collection efforts that will be taken; (4) how services will be limited or denied after discharge
  - Explicit discretion to determine how and when patients may be permitted to rejoin practice

# SLIDING FEE DISCOUNT PROGRAM

- **SVP Element j**: Refusal to Pay Policy
  - Policy review and documentation of cases where the center applied its refusal to pay policy within the last 2 years (if applicable)
  - Assess whether the center limits or denies services for refusal to pay, whether it has a policy/procedure that includes all required criteria, and whether determinations to limit or deny services was consistent with the policy/procedure

# QUESTIONS?

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# DON'T MISS THE REST OF THE COMPLIANCE MANUAL SERIES!

Next week: Tuesday, February 6th with Molly Evans:

- Quality & Personnel Dynamics: Ensuring Appropriate Clinical Staffing to Provide High Quality Care (Chapters 5 and 10)

Tuesday February 13th with Ted Waters:

- Internal Controls: Managing Your Grant Funds (Chapters 12, 13 and 15)

Tuesday February 20th with Molly Evans and Carrie Riley:

- Understanding the Roles of Management & Governance (Chapters 11, 19 and 20); the OSV Process As it Stands Today

# OTHER UPCOMING TRAINING EVENTS

| Webinars | | |
|---|---|---|
| Feb 8th @ 1 PM | HIPAA Breaches: Determining Whether a Breach Has Occurred and the Reporting Requirements | |
| Mar 13th @ 1 PM | Emergency Preparedness: Implementation Updates and Best Practices | |
| **Live Trainings** | | |
| Feb 13th – 14th | Health Center Compliance Intensive: HIPAA Fundamentals (*designed for Compliance Officers and Privacy Officers*) | Washington, DC |
| Feb 21st -23rd | Federal Funding Academy | Austin, TX |
| Feb 27th – 28th | De-Mystifying the New Compliance Manual & Its Impact on the Program Requirements | Mesa, AZ |
| Feb 28th – Mar 1st | An In-Depth Look at the Federal Tort Claims Act (FTCA) | Mesa, AZ |
| Feb 28th – Mar 1st | 340B Drug Discount Program: An Intensive Focus on Covered Entity Compliance | Washington, DC |

For more information and to register:
Email learning@ftlf.com or go to https://learning.ftlf.com