

SAMPLE POLICY ONLY

Please be sure to make all necessary changes to make this document appropriate for your county. (in red)

Fee, Eligibility & Billing Policies & Procedures

Rationale – Public health services are increasingly costly to provide. The Health Department serves the public interest best by assuring that all legally required public health services are furnished for all citizens and then providing as many recommended and public health services as it can for those citizens with greatest need.

_____ **County Health Department** provides services without regard to religion, race, national origin, creed, gender, parity, marital status, age or contraceptive preference.

Fees are a means to help distribute services to citizens of the county and help finance and extend public health resources as government funding cannot support the full cost of providing all requested services in addition to required services. Fees are considered appropriate, in the sense that while the entire population benefits from the availability of subsidized public health services for those in need, it is the actual users of such services who gain benefits for themselves.

Fees for Health Department services are authorized under North Carolina 130A-39 (g), provided that 1) they are in accordance with a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners, and 2) they are not otherwise prohibited by law. Fees are based on the cost of providing the service.

Note: Entity may wish to develop a pricing policy addressing establishment of usual and customary charges, applying income-based discounts, third party billing/reconciliation, Medicaid (physician administered drugs, fee for service drugs (340b), managed care, Medicaid as secondary payer). This information may be included in the agency's Fee and Eligibility or other financial policies.

Fees collected (generated through reimbursement) will be maintained in an identifiable line item in the Health Department and the County Finance Office.

_____ **County Health Department** has the right to require “proof of income” when determining eligibility for all programs, with the exception of Communicable Disease programs and state supplied Immunizations. Title X allows agencies to opt to use client’s self-report or attestation of income instead of requiring income documentation. Agency policy should reflect either “proof” of income or “attestation” of income but not the use of both.

Identification – It is considered “best practice” for each person presenting for services to establish identity either with a birth certificate, driver’s license, military I.D., passport, visa, or green card, etc.

A local health department may not require a client to present identification that includes a picture of the client for at least immunization, pregnancy prevention, sexually transmitted disease and communicable disease services (Consolidated Agreement, B, 11). However, you may take a photograph of the client, (with their permission) for internal use only.

DETERMINING GROSS INCOME

Gross income is the total of all cash income before deductions for income taxes, employee's social security taxes, insurance premiums, bonds, etc. For self-employed applicants (both farm and non-farm) this means net income after business expenses.

1. Alimony
2. Bank Statement
3. Cash (any cash earnings, contributions received)
4. Check Stub (includes regular wages, overtime, etc.)
5. Child Support (cannot consider as income for Family Planning)
6. Client Statement
7. Disability
8. Dividends
9. Employment Security Commission
10. Income Tax Return (annual, not quarterly)
11. Letter of Verification from Employer
12. Military Earnings Statement
13. NC Unemployment
14. Pensions
15. Social Security
16. SSI
17. Tips

Exceptions

1. Payments to volunteers under Title I (VISTA) and Title II (RSVP, foster grandparents, and others) of the Domestic Volunteer Service Act of 1973
2. Payments received under the Job Training Partnership Act
3. Payments under the Low Income Energy Assistance Act
4. the value of assistance to children or families under the National School Lunch Act, the Child Nutrition Act of 1966 and the Food Stamp Act of 1977
5. **Veteran's Disability payments**

No client will be refused services when presenting for care based on lack of income documentation, however each client will be billed at 100% until proof of income and family size is provided to the agency. The client will have _____ days (agency may determine time limit) to present this documentation in order to adjust the previous 100% charge to the

sliding fee scale. If no documentation is produced in _____ days then the charge stands at 100% for that visit.

DETERMINING FAMILY SIZE

A family is defined as a group of related or non-related individuals who are living together as one economic unit. Individuals are considered members of a single family or economic unit when their production of income and consumption of goods are related. An economic unit must have its own source of income. Also, groups of individuals living in the same house with other individuals may be considered a separate economic unit if each group support only their unit. A pregnant woman is counted as two (including the unborn child) in determining family size.

Examples:

1. A foster child assigned by DSS is a family of one with income considered to be paid to the foster parent for support of the child.
2. A student maintaining a separate residence and receiving most of her/his support from her/his parents or guardians may be counted as a dependent of the family. Self-supporting students maintaining a separate residence would be a separate economic unit.
3. An individual or family in an institution is considered a separate economic unit.
4. If a patient requests “confidential services”, regardless of age, the agency should consider them a family unit of one based on their income.
5. If a Family Planning patient presents for a service and is considered to be a minor, interview questions may include the following: 1) Ask the patient if their parents are aware of their visit? 2) Ask if “both” parents are aware of their visit, since sometimes the mother may be present with the patient, however, the father may not be aware of the visit. 3) Ask if you can send a bill to the home, to both parents. 4) If the patient states both parents are aware and it is not a confidential visit, you should treat as such.

Computation of income*

***This is an in-house/agency decision**

Regular Income Formula:

The patient’s income will be determined by the following:

Income will be based on a twelve (12) month period. If the patient is working the day they present for a service, income will be calculated weekly, bi-weekly, monthly or annually, depending on the documentation obtained. If the patient is unemployed the day they present for their service, their “employment only” income will be calculated at zero (0), however the patient should be required to provide “their mechanism”, in regards to their paying for food, clothing, shelter, utility bills, etc. Refer to “sources of income” counted and apply all sources, as appropriate. “Regular contributions received from other sources outside of the home” is most often considered one of those sources. If the patient is receiving unemployment or other “sources” of income, as designated above, all of those sources should be counted.

Unemployment or Irregular Income Formula:

- Six months' formula
- Wage earners unemployed at time of application
- Unemployed any time during previous 12 months
- Example: Unemployed today
- Income determined six months' back
- Income determined six months' forward
- Total = 12 months of income

A copy of the Financial Eligibility Determination should be maintained for future reference. The number in the household, annual gross income and percentage of pay should be reflected on the financial documentation. The documentation should be signed and dated by the interviewer and patient. Use of electronic signatures is acceptable.

Income is re-assessed annually unless there has been a change in financial status. Following the initial financial eligibility determination, the client will be asked at each visit if there has been a change in their financial status. Income will always be based on the "actual date" of service. If there has been a change or it is time for their annual review the income determination process should take place.

Client fees are assessed according to the rules and regulations of each program and the recommended Program's Poverty Level Scale (Sliding Fee Scale) will be used to determine fees. All third-party providers are billed where applicable.

Commented [BK1]: Changed from 'patient' for consistency

Clients presenting with third party health insurance coverage where copayments are required shall be subject to collection of the required copayment at the time of service. For Family Planning (Title X) clients the copay may not exceed the amount they would have paid for services based on sliding fee scale.

Income information reported during the financial eligibility screening for one program can be used through other programs offered in the agency, rather than to re-verify income or rely solely on the client's self-report.

BREAST AND CERVICAL CANCER CONTROL PROGRAM (BCCCP)

Provides pap smears, breast exams and screening mammograms, assists women with abnormal breast examinations/mammograms, or abnormal cervical screenings to obtain additional diagnostic examinations.

Eligibility: _____ County resident; determined by specific policies and procedures including income guidelines defined by the Breast and Cervical Cancer Control Program (BCCCP). 101-250% Sliding fee scale is used.

1. Healthy Mothers Healthy Children (HMHC)/Title V (Well Child funding)

Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client participation in the cost of the service (as per Peter Andersen, (Women's and Children's Health (WCH) Acting Section Chief).

The guidance regarding Title V funding and sliding Child Health services to zero is as follows: Any Maternal and Child Health services (even outside of Child Health Clinics) must use a sliding fee scale that slides to "0" at 100% of the Federal Poverty Level per the NC Administrative Code – 10A NCAC 43B.0109 Client and Third Party Fees.

The NC Administrative Code goes beyond the Title V/351 AA requirements, that all child health services, whether sick or well, no matter where delivered, must be billed on a sliding fee scale that slides to zero.

10A NCAC 43B .0109 CLIENT AND THIRD-PARTY FEES

- (1) If a local provider imposes any charges on clients for maternal and child health services, such charges:
 - (a) Will be applied according to a public schedule of charges;
 - (b) Will not be imposed on low-income individuals or their families;
 - (c) Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
- (2) If client fees are charged, providers must make reasonable efforts to collect from third party payors.
- (3) Client and third-party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.

History Note: Authority G.S. 130A-124; Eff. April 1, 1985; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017

CHILD HEALTH/HEALTH CHECK

Well child exams (Health Check) conducted by (appropriate provider); exam includes medical, social, development, nutritional history, lab work, physical exam and immunizations as needed.

Primary Care (Child Health) for sick children provided by (appropriate provider).

Eligibility: _____ County resident; birth to 20 years; sliding fee scale; Insurance; Medicaid

MATERNAL HEALTH

Prenatal care for eligible pregnant women.

Eligibility: _____ County residents. Sliding fee scale; Medicaid or **Presumptive Medicaid** eligible, Insurance

COMMUNICABLE DISEASE CONTROL

This Program deals with the investigation and follow-up of all reportable communicable and/or sexually transmitted diseases, to include: testing, diagnosis, treatment, and referring as appropriate. It also provides follow-up and treatment of TB cases and their contacts.

Eligibility: No residency requirements. Medicaid can be billed, no fees charged to the client for these services as stated in Program Rules.

FAMILY PLANNING OR WOMEN'S HEALTH SERVICES

Clinic designed to assist **men and** women in planning their childbearing schedule; detailed history, lab work, physical exam, counseling and education given by (**appropriate provider**).

Eligibility: **Men and** Women of childbearing age regardless of residency; sliding fee scale, Medicaid, Insurance

The following shall apply to Family Planning patients:

- (1) If a patient is considered to be "confidential" this will be documented on the Financial Eligibility form.
- (2) The sliding fee scale, used for Family Planning patients will reflect 101%- 250%.
- (3) The use of NC Debt Setoff is acceptable for collecting past due amounts for Family Planning patients.
- (4) Confidential clients should ~~only~~ NOT be referred to Debt Set-off if the LHD can ensure that the clients' confidential status will not be compromised by going through the Debt Set-off process."
- (5) The "Bad Debt Write-Off" method of aging accounts will be strictly followed. The list of bad debts should be approved by the Health Director, prior to submission to the Board of Health (**or appropriate governing board**). Bad debts will not be written off until the approval of the Board of Health (or appropriate governing board) has been acquired. Board of Health (**or appropriate governing board**) minutes will serve as documentation that the write-offs have been approved.
- (6) Bills/receipts given to clients at the time of service show total charges, as well as any allowable discounts
- (7) Where a third party is responsible, bills are submitted to that party. Bills to third parties show total charges, without discounts, unless there is a contracted reimbursement rate that must be billed per the third party agreement
- (8) For FP, you may collect the copay or their SFS amount due: whichever is lower (a Title X requirement). [OPA- Title X Program Requirements April 2014](http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf), <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf> section 8.4.6.
- (9)

340b DRUGS AND DEVICES

County Health Department bills Medicaid the acquisition cost of medication or devices purchased through the 340b drug program. All 340b drugs and devices are identified with a UD modifier in the _____ billing system. 340b drugs and devices are billed to Medicaid with an FP and UD modifier. Drugs and devices purchased through the 340b program are labeled as 340b and stored separately from other medications and supplies.

OTHER SERVICES

Please refer to the Coding & Billing Guide on the DPH/LHD website for information regarding changes to OS and PC service approval.

Only those services approved by the Head of Local Technical Assistance & Training Branch may be identified as Other Services (e.g. pregnancy test; TB skin test; blood testing for work; ~~private purchased vaccines~~; etc.)

Eligibility: _____ County resident, fees vary

WOMEN, INFANTS, AND CHILDREN NUTRITION PROGRAM (WIC)

Supplemental nutrition and education program to provide specific nutritional foods and education services to improve health status of target groups.

Eligibility: WIC is available to pregnant, breastfeeding, and postpartum women as well as infants and children up to age 5. The following criteria must also be met: 1) be a resident of _____ County; 2) be at medical and/or nutritional risk; 3) have a family income less than 185% of the US Federal Poverty Level; Medicaid, AFDC, or food stamps automatically meet the income eligibility requirement.

Billing & Revenue

In accordance with G.S. 130-A-39(g), which allows local health departments to implement a fee for services rendered the _____ County Health Department, with the approval of the _____ County Board of Health and the _____ County Commissioners (or appropriate governing body) will implement specific fees for services and seek reimbursement. Specific methods used in seeking reimbursement will be through third-party coverage, including Medicaid, Medicare, private insurance, and individual patient pay. The agency will adhere to billing procedures as specified by Program/State regulations in seeking reimbursement for services provided.

_____ County Health Department will use the following Federal Poverty Scale for programs that charge fees:

Family Planning 101-250% Federal Poverty Scale
Breast and Cervical Cancer Control 101- 250%
Child Health – agency decision

Maternal Health – agency decision
Adult Health/Primary Care – agency decision
~~Primary Care – agency decision~~
~~Other Services – agency decision~~

Direct Patient Charges

1. There shall be no minimum fee requirement or surcharge that is indiscriminately applied to all patients.
2. Persons requesting program services will be encouraged but not required to apply for Medicaid.
3. No patient charges shall be assessed when income falls below 100% of Federal Poverty Guidelines.
4. There shall be a consistent applied method of “aging” accounts.
5. No one shall be denied services based solely on the inability to pay.
6. Patients shall be given a receipt each time a payment is collected
7. Donations shall be accepted from any patient regardless of income status as long as they are truly voluntary. The patient account will not be reduced due to a donation. There shall be no “schedule of donations”, bills for donations, or implied or overt coercion.
8. Provider will use best efforts to continue to provide services to patients at or below 150 % of Federal Poverty Level.

Fee Collection:

1. Charges in all programs will be determined by a fee scale based on Federal Poverty (with the exception of any services charged at a set rate (i.e. TB skin test, Non-programmatic pregnancy tests, Adult Health) services).
2. Upon each clinic visit, Management Support staff will determine the income and sliding fee scale status of each patient. Staff will be responsible for documentation of financial eligibility on _____ (whatever form/format your department used to determine eligibility). Patients without required verification will be expected to pay full charge until income documentation is received.
3. Payment is due and expected at the time services are rendered. If a balance remains, a payment agreement and schedule will be established and signed by the patient (see Appendix B- Sample Payment Agreement)
4. Enrollment under Title XIX (Medicaid) shall be presumed to constitute full payment for billable services to Medicaid.
5. Monthly statements will be mailed to the client/responsible party as long as confidentiality is not jeopardized.
6. Outstanding accounts having no activity in more than ____ months shall be written off as bad debts.
7. When appropriate patient accounts may be submitted to the NC Debt Setoff Program. Minimum time outstanding for DSO is 60 days with an additional 30 days for the notification letter to be sent

8. All staff members involved in fee services shall consistently follow the established guidelines for fee collection through the policy and procedure statements addressed in this document, and shall hold all client information confidential.
9. The Accounts Receivable System will be balanced **daily** (see Appendix E- Cash Handling Policy)
10. Emergency services will never be denied.
11. The agency ensures that there is a mechanism in place for waiving fees of individuals who, for good cause, are unable to pay but do not qualify for the schedule of discounts (SFS). This process is approved by the Health Director or their designee.

Limiting or Restricting services

- Women's Health: The Title X guidelines do not distinguish between "inability" and "unwillingness" to pay. For FP patients who do not pay, the agency can use debt set-off. Even if a patient establishes a payment plan but then refuses to honor the plan services cannot be denied or restricted.
- In Maternal Health, denying or restricting services would constitute patient abandonment. Therefore, services for Maternal Health may not be denied because a patient is unwilling or unable to pay.
- Child Health may not restrict CH services due to an outstanding bill. Title V funds are used to prevent barriers to care for clients that are Non-Medicaid, non-insured as well.

Billing Medicaid and Third-Party Insurance

1. Clients presenting with third party health insurance coverage where copayments are required shall be subject to collection of the required copayment at the time of service. For Family Planning (Title X) clients the copay may not exceed the amount they would have paid for services based on sliding fee scale.
2. Patients will electronically sign a consent allowing the Health Department to file insurance and a copy of the insurance card will be scanned at that time into the patient's medical record
3. Third party is billed the total amount of the service provided they will not receive the benefit of the SFS. The charge and any remaining balance (minus copayments) is billed to the client based on the SFS.
4. Claims are filed electronically using **(add the name of the vendor product(s) you use)**
5. Payments are posted electronically/manually to patient accounts. If applicable, secondary insurance is filed.
 1. Denials are researched using the Remittance Advice (RA) for Medicaid and EOB's for private insurance. Any denials deemed incorrect are resubmitted as quickly as possible. Any remittance or final denial is posted to the patient's account. Remaining balance for Medicaid clients are adjusted off. (unless it was for a non-covered service that the client was made aware of prior to the service being rendered.)
 - a. If a patient has any form of third-party reimbursement, that payer must be billed (required if the agency is "in network", otherwise optional), unless confidentiality is a barrier*. Medicaid will be billed as the payer of last resort. Patients should be made aware that they will be responsible for any balance remaining after the claim has been processed. This may include copays, coinsurance, deductibles and non-

allowed charges (applied to sliding fee scale). Family Planning clients will pay the lesser of the copay or where they fall on SFS as required by Title X.

The confidential patient may give you their insurance card not thinking that the subscriber is not aware of the visit. Filing an insurance claim will result in an EOB (explanation of benefits) being sent to the subscriber which would violate confidentiality. **Be certain to have the client sign/initial if they want insurance to be filed.*

No Mail Policy for Confidential Patients

1. When a client requests no mail, discussion of payment of outstanding debts shall occur at the time service is rendered.
2. If the client is unable to pay in full at the time of service rendered, a receipt will be given to the client reflecting the partial payment and the client will sign a payment agreement.
3. Medical record is flagged reflecting-- **“NO MAIL” and every precaution should be taken to ensure bills are “not” sent to clients, requesting “NO MAIL”.**
4. Client is reminded every visit of the amount they still owe.
5. No letters or correspondence concerning insurance, past due accounts or other billing issues will be sent to any patient that requests “NO MAIL”.

(on letterhead)
_____**County Health Department**
Payment Agreement
EXAMPLE

In accordance with the policy of the Health Department, payment is due when a service is rendered. However, we realize that there are times when an individual does not have the total amount of money owed to the clinic, therefore, this written agreement is established as a method of adopting a payment plan for those clients who have an outstanding balance.

NAME----- DATE OF BIRTH ----- ADDRESS-----
AND OTHER INFORMATION, AS REQUIRED

I, _____, agree to establish a payment plan for my account and to the stipulations herein stated:

_____ My account balance is \$ _____

_____ I will pay the amount of \$ _____ on my bill

_____ Monthly_____ Weekly_____ Bi-weekly_____

_____ I understand that the _____County Health Department cannot operate efficiently without me adhering to the agreement as stated above. I further state that my options were explained to me and I fully understand.

_____ I understand that I am responsible for any balance left owing if my insurance company should not pay the bill in full and that it will be based on my sliding fee scale status.

This is a binding agreement by signatures of both parties.

I understand that failure to comply with this agreement will greatly affect the overall operations of the Health Department and may result in my debt being referred to NC Debt Setoff for collection.

Signature of Client _____

Signature of Witness _____

Cash Handling Procedures

EXAMPLE

Each department will establish policies and procedures for the acceptance of cash at their various work sites. The Finance Officer will review and approve all policies and procedures involving the handling of County cash. These procedures should be written to address the unique circumstances of individual locations receiving cash. The following procedures are currently followed for all Treasury operations, and are recommended to be included in departmental policies and procedures.

1. Daily Cashiering Operations

- a. Each employee responsible for handling cash on a reoccurring basis will maintain an individual drawer or lockbox for which they are solely responsible. At the beginning of each daily shift the cashier should do the following:
 1. Arrange coin currency in a consistent manner. The cash drawer or lockbox should be divided into separate compartments for different currency denominations, checks, etc. This setup helps prevent accidental distribution of incorrect denominations.
 2. Verify the dollar amount of beginning cash. If beginning cash should be \$50, for example, verify this amount through an opening count of all cash. The cash count should be recorded and initialed by the individual making the count.

- b. During the cashier's hours of operation, the following procedures will be observed to monitor the cash drawer.
 1. All cash and coins must be locked in the cash drawer, lockbox, safe or other safe secure location when not in use.
 2. Never leave the cash drawer or lockbox unattended.
 3. Never let anyone handle the drawer, unless under the direct supervision of the cashier responsible for the drawer.
 4. The cash drawer is never to be used for the purpose of making change for the personal use of the cashier, cashing personal checks, or providing temporary "loans" for the benefit of the cashier or other individuals.
 5. Each cashier must have a permanent collection record, (example: numbered receipt, computerized daily collection/deposit) that records all transactions including voids, refunds, etc. This permanent record must be retained by the department for duration of three (3) years.

Losses/Shortages/Overages

Any Shortage or Overage will be reported as part of the department's net deposit for separate reporting on the County's General Ledger. The Finance Office makes a clear distinction between a "Loss" and "Shortage" of department money:

- b. An **Overage** occurs when a cashier has collected too much money and cannot immediately return the excess money to a specific client
- c. A **Shortage** is an unintentional collection error such as an error made in making change.
- d. A **Loss** of County money is when a cashier has obtained physical custody of money and then, due to reasons of negligence (such as leaving the drawer unattended), an act of God (such as a hurricane), or an unlawful action (such as robbery), cannot deposit that money into the County treasury. Any loss must be immediately reported to the supervisor and to the County Finance officer. The Finance Officer must be sent a detail statement as to the circumstances of the loss, along with a copy of the Police Report within 24 hours of the loss. (Specific to agency/county policy)

2. Daily Deposits

§ 159-32. Except as otherwise provided by law, all taxes and other moneys collected or received by an officer or employee of a local government or public authority shall be deposited in accordance with this section. Each officer and employee of a local government or public authority whose duty it is to collect or receive any taxes or other moneys shall deposit his collections and receipts daily. If the governing board gives its approval, deposits shall be required only when the moneys on hand amount to as much as two hundred fifty dollars (\$250.00), but in any event a deposit shall be made on the last business day of the month. All deposits shall be made with the finance officer or in an official depository. Deposits in an official depository shall be immediately reported to the finance officer by means of a duplicate deposit ticket. The finance officer may at any time audit the accounts of any officer or employee collecting or receiving taxes or other moneys, and may prescribe the form and detail of these accounts. The accounts of such an officer or employee shall be audited at least annually. (1927, c. 146, s. 19; 1929, c. 37; 1939, c. 134; 1955, cc. 698, 724; 1971, c. 780, s. 1; 1973, c. 474, s. 27.)

3. Intent of Rules and Procedures

All cashiers are given the responsibility to protect the assets of the **County of _____**. These rules and procedures are given as guidelines to assist cashiers in carrying out their duties. The department has primary responsibility for care and liability for loss of County cash in its custody until deposited in the official depository or entrusted to an authorized individual in the Finance Office for deposit in the official depository.