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Section: 02: Financial Management
References:

Accounts Receivable

A. General Description

In order to maintain accurate accounts receivable information, it is charges for services rendered are posted to the Agency's billing system in a timely manner. In addition, consistent policies related to collection, refunds and estimated bad debt are followed and monitored for accuracy.

PROCEDURES

1. Fee Collection and Refunds

See Cash Management policy.

2. Bad Debt Policy

Compass Health shall make every effort to collect balances owed for services provided. If collection cannot be made clients will be notified through a series of letters and communications in the internal collections process that non payment could lead to turnover to a collection agency. Compass Health will maintain an allowance for bad debts to cover expected uncollectable accounts. Periodically accounts will be reviewed for formal write off. Formal write of shall be approved by the CFO or their designee.

3. AR Oversight

In an effort to maximize program revenue, it is the policy of Compass Health that the agency will routinely monitor accounts receivable to provide assurance that amounts owed from third parties and individuals are paid in a timely manner. Accounts receivable aging reports will be reviewed by management on a regular basis, with any deviations from normal aging expectations being investigated. To account for potential uncollectible accounts receivable, the agency will employ a reasonable and effective methodology to estimate the amount of uncollectible accounts, and will accrue this estimation within its financial statements on a regular basis. This method may include scrutinizing of the aging, analysis of collection histories, and consideration of other factors that may lead an account balance to be uncollectible.

4. Charge Entry

- a. Behavioral Health clinicians in the out-patient services department and community based services use a catalogue of approved clinical services to select the appropriate clinical transaction that needs to be documented for clinical and billing purposes. There are many types and lengths of clinical transactions. Some are billed in minutes, some by event, and some daily. All clinical services must be documented within 72 hours of service delivery. Productivity reports are produced weekly for monitoring by department managers to ensure client and billing information is documented in a timely manner.

- b. Medical and Dental providers use a set of ICD (International Statistical Classifications of Diseases) Codes to report medical diagnoses and patient procedures.
- c. All paper and electronic clinical transactions must be documented with all required information and must be signed by the staff member completing the work. Paper SAL's must be neat, accurate, and legible.
- d. Practicum students may bill for services rendered once they receive temporary privileging from the Continuous Quality Improvement Committee (CQI) in accordance with their level of education and experience. Practicum students billing for services rendered are responsible for following the clinical transaction billing policies in the same manner as a paid Compass Center employee.

5. Establishing fees

Compass Health is a nonprofit health care organization financed by client fees, third party reimbursement, grants, contracts, contributions, and support from local, state, and federal governments. As part of its overall mission, the Agency recognizes its responsibility to serve residents regardless of their ability to pay the full cost of the services they receive. As such, individuals in need of service may be eligible for a discounted or subsidized fee. Eligibility for discounts or subsidies is based on the client's income and family size.

The company's standard fee schedule is determined by considering its costs for providing a particular service in addition to assessing local market rates. Both the standard fee schedule and the discounted fee scale are available to persons served at any time.

For medical and dental services, the customer's payment responsibility is determined during the admission process. If uninsured or under-insured, the customer may qualify for the agency's Sliding Fee Program, which uses annual income and family size to assess eligibility for reduced fees. Please refer to Compass Health's sliding fee scale for more details about this program.

Customer fees are subject to adjustment should changes in the customer's financial status or family size occur during the course of treatment. Clinic Registration Specialists verify each customer's insurance status at each clinic appointment. If there is a change in insurance status, the Registration Specialist will reassess the customer's financial status at that time. In addition, customers are interviewed annually by the Registration Specialists to reassess their financial status and to determine their position on the sliding fee scale. Should a change in a customer's financial status come to the attention of the Agency prior to the yearly review, the arrangements will be made for an earlier financial interview.

Each fiscal year, Compass Health will review its fee schedules to determine whether or not changes to any standard fees should be made. During this review, the Company will take into account total costs required to provide its services, profit margin required to maintain operating reserves, facilitate future expansion efforts and local market rates to determine whether or not its fees need to be changed. After review by the Executive Team, the annual fee schedule changes will be brought to the Board for approval. The Board will also approve the Sliding Fee scale for services funded by the 330 grant on an annual basis in conjunction with any fee schedule changes.

During the course of business, there may be instances in which a service code needs to be billed for which a standard fee has yet to be included in our fee schedule. Under these circumstances, the Controller is to utilize the above outlined measures to determine the appropriate fee for the service rendered.

6. Sliding Fee Scale

It is the policy of Compass Health, based on the requirements set forth in Section 330(k)(3)(G) of the Public Health Service Act and 42 C.F.R. § 51c.303(f), to establish discounts to its established schedule of fees. This policy is designed to reduce barriers to accessing health services (including pharmacy) for such patients. The sliding fee scale and nominal fee will apply to patients who receive outpatient services (except those who are eligible for Department of Mental Health funding) without health insurance who do not qualify for Medicaid, to

patients with health insurance when their insurance does not cover a particular service, and to cost-sharing amounts for insured patients who qualify for a discount. However, the sliding fee scale will not apply to pharmacy services in the event that a patient qualifies for free drugs under any pharmaceutical-sponsored Patient Assistance Program.

Further, it is the policy of Compass Health that no patient will be denied health services due to an individual's inability to pay for such services or to document eligibility for a discount. Nor will the operating procedures for assessing patient eligibility and collecting payment create barriers to care. The Sliding Fee Discount is based on the Federal Poverty Guidelines published by the U.S. Department of Health & Human Services. These guidelines are updated in January of each calendar year and are available at: <http://aspe.hhs.gov/poverty/index.shtml>.

Compass Health's Sliding Fee Scale Program is reviewed and updated annually with approval from the Board of Directors. Updates are consistent with the requirements established by the Board of Directors, Compass Health's senior management, federal/state laws and regulations, and applicable accrediting organizations.

It is the intent of Compass Health to evaluate the overall effectiveness of the program by examining the following:

- Fee Schedule taking into consideration reasonable costs and locally prevailing charges;
- Sliding Fee Discount Schedule (SFDS) and structure;
- The Sliding Fee Discount Program Policy and Procedures including those policies that are associated with the program;
- Overall Operating Procedures; and
- Program compliance.

All aspects of the program will be applied uniformly to all patients and supported by the operating procedures. This includes: eligibility process; definitions of income and family size (what is included or excluded); frequency of re-evaluation of patient eligibility; documentation and verification requirements for determining eligibility; alternative mechanisms for determining patient eligibility; structure of the SFDS; use of multiple SFDS; establishing and collecting nominal charges; provisions for waiving fees and nominal charges for specific patient circumstances; billing and collections including payment plans, refusal to pay guidelines, billing patients, and billing third party payors; other discounts relative to supplies, equipment, or specific services; monitoring of the program through internal audits; and staff training.

Procedure

A. Establishing Discounts

1. General Description

Compass Health has established: (a) a sliding fee schedule for uninsured and under-insured patients whose annual individual or family incomes do not exceed 200% of the most current Federal Poverty Guidelines (FPG) published by the Department of Health and Human Services (DHHS); and (b) a nominal fee for uninsured and under-insured patients with annual individual or family incomes at or below 100% of the most current FPG published by DHHS. The nominal fee consists of a minimal amount to support the cost of care, taking into account cost of living and other factors specific to the demographics and location of the health center. The sliding fee scale and nominal fees are approved by the Board of Directors. Further, they are reviewed and updated by the Board of Directors annually to ensure that charges to patients do not become a barrier to care. Payment plans available to patients as needed.

2. **Medical and Behavioral Health Services**

Patients who qualify for the sliding fee program for medical and behavioral health services will be placed into one of four categories depending on their family size and gross household income:

- a. Slide A- 100% or less of Federal Poverty Guidelines = \$20.00
- b. Slide B- 101% to 135% of Federal Poverty Guidelines = \$30.00
- c. Slide C- 136% to 165% of Federal Poverty Guidelines = \$40.00
- d. Slide D- 166% to 200% of Federal Poverty Guidelines = \$50.00

(Patients over 200% of FPG are Full Fee) Fees include the office visit and a limited number of services and labs. For Well Woman Exams the Pap test is included in the fee. Patients will be notified of additional charges prior to any procedures and/or labs. The list of labs included in this co-pay will be determined by Compass Health administration and will be reviewed on an annual basis for cost and appropriateness.

1. **Dental Services**

Patients who qualify for the sliding fee program for the following dental services will be offered the following discount schedule: i.

- a. Slide A- 100% or less of Federal Poverty Guidelines:
 - i. Slide Comprehensive Exam and X-Rays: \$20.00
 - ii. Single Extraction: \$80.00
 - iii. Single Filling: \$80.00
 - iv. Cleaning: \$50.00
2. Slide B- 101% to 135% of Federal Poverty Guidelines = \$30.00 + (plus) 50% of Standard Fee
3. Slide C- 136% to 165% of Federal Poverty Guidelines = \$40.00 + (plus) 65% of Standard Fees
4. Slide D- 166% to 200% of Federal Poverty Guidelines = \$50.00 + (plus) 65% of Standard Fees.

Patients over 200% of Federal Poverty Guidelines are Full Fee. Co-pay applies to the exam and x-rays, then percent of Standard Fee as noted above. Non essential services for slide A are charged at 50% of the Standard Fee.

1. **Use of Multiple Scales**

As noted above, Compass Health has established a separate SFDS for medical/behavioral health and dental services. In developing the SFDS's, the locally prevailing charges along with the overall cost of care including supplies and equipment for each service type was taken into consideration. Patient access and uniform implementation were also a factor in making this decision. The health center has a plan for routinely evaluating each SFDS to ensure that it does not create a barrier to care.

1. **Other Services Considerations**

As a means of reducing barriers to care, maximizing access, and improving health outcomes for the patient population, Compass Health has established a structure of charges for specific circumstances such as flu shots, sports physicals, and certain labs. (See Fee Schedule for more information)

2. **Publicizing Discounts**

Compass Health shall inform all patients of the availability of discounts through multiple means such as signage in public places at the health center, notifications on intake forms, a sliding fee scale program

informational pamphlet, and on the health center's website. In addition, the Sliding Fee Discount program is also explained to patients during the registration and intake process. All informational materials about the program are available in English and Spanish.

3. **Application of Discounts**

Patients who have completed an eligibility application form, submitted income verification documentation, and who have been determined eligible for a discount will be charged in accordance with the sliding fee scale or nominal fee as applicable.

4. **Eligibility Determination Process and Documentation**

The appointed registration and reception staff will assist patients in completing an eligibility application form and will collect any relevant income verification documentation from patients. Whenever possible, completion of the eligibility form and collection of income verification documentation will occur prior to the health center's rendering health care services to the patient, or as soon thereafter as is reasonable, but always prior to the application of the discount. Nonetheless, under **no circumstances** will health care services be withheld or denied on account of delay of the eligibility documentation process. **Patients who do not bring in the required documentation will be given the option to reschedule their appointment or to pay full fee. Once eligibility documentation is presented, the sliding fee scale will be applied from that visit forward and will not be retroactive (except in the case of incorrect Medicaid eligibility verification on the part of the agency).** At any time, while receiving assistance through the slide program, the patient is required to report any changes in household occupancy or financial status for re-evaluation. If this occurs, new eligibility forms and collections of income verification documentation will be required of patients. Failure to report any changes may make the sliding fee agreement invalid.

Patients who refuse to provide proof of income and family size are viewed as having declined to be assessed for slide eligibility and are considered ineligible for discounts. Copies of all eligibility forms and income verification documentation will be retained by the health center according to the established document retention schedule.

The qualifying procedure breakdown and payment schedule for patients enrolled in the sliding fee program are as follows (Please refer to the Sliding Fee Desk Reference Guides for detailed information on how these parameters are applied):

5. **Members of Household/Family Size** Family size is determined by the number of individuals depending upon or contributing to the income of the client/patient. It is essentially the number of persons for whom the head of household is financially responsible for. Household Members to include are persons living in that home who are:

1. Head of household;
2. Spouse;
3. Children age 18 and under;
4. Dependent children over the age of 18 (must provide proof of dependency);
5. Children of divorced/separated parents who share custody and are claimed as dependents (must provide proof of dependency);
6. Grandchildren and any other children/individuals when legal guardianship has been granted (must provide proof); and/or
7. Any other relatives or nonrelated individuals that are claimed as dependents (must provide proof of dependency).

2. Sources of Income

- a. Gross Wages/Salaries/Tips
- b. Unemployment Compensation
- c. Worker's Compensation
- d. Earnings from need-based employment programs
- e. Welfare Benefits - TANF, General Relief (Does not include non-cash benefits such as food stamps, subsidized housing, and WIC)
- f. Social Security Disability and Retirement
- g. Supplemental Security Income
- h. Survivor's Benefits
- i. Pensions and retirement
- j. Veteran's Benefits
- k. Alimony
- l. Income from estates, royalties, trusts, investment interest, dividends, and rent
- m. Regular Contributions from persons not living in household (only if there is a set amount received, the frequency is established and consistent, and proof is provided)

3. Proof of Income

- a. Last two (2) consecutive pay stubs
- b. Total Income from the prior year's tax return if it is reflective of current income (Exception: Form 1040EZ use adjusted gross income as it is the same as total income)
- c. Statement of Benefits (Social Security, Unemployment, Pensions, etc)
- d. Employer earnings statement/letter
- e. Federal or State Award Letter

4. Alternative Eligibility Determination Methods

Patients who state that they have no income or it is unfeasible for them to provide documentation will be required to sign a Responsibility Statement self declaring their income. The statement attests that the information they have provided is true and accurate. It further explains that if a discrepancy is found the patient may be 100% liable for charges and may be deemed ineligible for the sliding fee program. Patients who refuse to sign this statement will be ineligible for the sliding fee scale program.

5. Exceptions

Patient eligibility circumstances not described in this policy and any exceptions to the documentation requirement for eligibility will be reviewed and determined by management that oversees the sliding fee program. These decisions will be made on a case by case basis.

E. Frequency of Re-evaluation Period

The effective date of enrollment in the Sliding Fee Program is the date of application and eligibility determination. The sliding fee remains in effect for one year. At that time or upon the patient's next visit to the health center the patient must reapply for the sliding fee program. This process is the same as the initial

eligibility determination procedures requiring the completion of the application forms and gathering of supporting documentation.

F. Billing and Collections

Compass Health shall make a reasonable effort to collect all charges for health care services rendered, regardless of whether discounted charges or standard charges are applied. Attempts will be made to maximize revenue from public and private third party payors. Education will be provided to patients on options available to them based on their eligibility for insurance and/or related third party coverage.

1. Third Party Payors (Medicare, Insurance and Medicaid Patients)

Compass Health will make every reasonable effort to obtain reimbursement from Medicare, Medicaid, CHIP, or other public assistance programs and private third party payors in accordance with requirements specified in statute, regulations, policies and/or contract terms/conditions. Initial billings take place within 30 days from the date of service. All denied claims are reviewed and scrutinized by the assigned billing personnel. Any claim that can be corrected will be fixed and re-billed appropriately.

2. Billing Patients

Compass Health will make reasonable efforts to secure payment from patients for services rendered taking into consideration the limits of the patient's ability to pay. It is not the intention of the agency to place barriers to service, but to encourage easy access while keeping in mind that fiscal responsibility is also important to continue serving our community. A reasonable effort may include, but is not limited to, issuance of a bill to the patient or responsible party within 30 days of the date of service and monthly thereafter until the amount owed is paid in full.

Patients are expected to provide payment, including sliding fee charges on the day the service is given. Patients will be reminded of their expected payment by the registration staff during their appointment confirmation call prior to their appointment. This reminder will also happen upon checking in for their appointment at the clinic. If upon initial exam the provider determines the patient will need additional services not covered by the co-pay, the patient will be informed and referred to the designated staff for additional information regarding the costs of the recommended services. If the patient chooses to receive the additional services and is not prepared to pay for them on the day it is rendered, an option to set up a payment plan will be offered. The patient will sign a payment agreement form stating they understand they are responsible for the payment of additional medical services. All billing and collecting from patients will be conducted in an efficient, respectful and culturally appropriate manner.

3. Refusal to Pay

It is important to note that a patient's refusal to pay does not equate to an inability to pay. An account is deemed "refusal to pay" when a patient does not make efforts to pay their debt and honor the payment agreement. If after the above mentioned billing and collection protocols are carried out and the account still is not paid off 3 months from the date of service, it will be placed in bad debt status. Once placed in bad debt status, the patient will be issued 3 collection letters from the billing department. If after 3 collection letters have been mailed (6 months from the date of service) the patient has yet to pay the amount owed and/or be placed on a payment plan, the account will be reviewed by the billing manager to determine what steps will be taken next. The billing manager will place an alert in the practice management system regarding the patient's bad debt status as an indicator to the front office staff to not schedule future visits with the patient unless fully recovery of bad debt is received, or a payment plan for full recovery is initiated. Decisions on bad debt status including exceptions and future scheduled visits will be made by vice president level staff, Medical Director or Dental Director.

4. Confidentiality

In accordance with the HIPAA Privacy Rules, all personal information and records are kept confidential and will not be shared without the approval of the patient. At the time of intake and annually, patients are notified of the confidentiality and security protections.

Please refer to Compass Health's Billing & Fee Collection Policies & Procedures for more detailed information.

G. No Denial of Services for Inability to Pay

Regardless of whether a patient qualifies for a discount, if a patient would be denied services due to inability to pay, then charges will be waived or reduced to the extent necessary to ensure that such patient receives health care services. A staff member will assist the patient with the development of a payment plan.

H. Staff Training

All staff responsible for completing sliding fee paperwork will be trained on the Sliding Fee Program policy and procedures according to the front desk procedures. This training includes staff expectations and protocols.

I. Monitoring of SFD Program

The Sliding Fee Program will be monitored regularly for compliance through random testing of new and established sliding fee patient files. This will entail checking files for required sliding fee paperwork, annual paperwork completed on time, verify income calculations, determine if the slide is applied appropriately, and confirm there is documentation to support eligibility determination. Through this, the eligibility screening process will be analyzed for effectiveness. Any concerns or trends will be communicated to management responsible for the Sliding Fee Program and a corrective action plan will be developed and implemented.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Rhonda Meyer: Vice President of Administrative Services	02/2015
Keri Harrell: Executive Assistant	02/2015
David Turner: Chief Financial Officer	02/2015