

W.J. Brodine & Co.

The HRSA Operational Site Visit: “Hot Issues” for HealthCare for the Homeless Programs

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PRESENTER: MARCIE ZAKHEIM

- Partner at Feldesman Tucker Leifer Fidell, specializing in, among other things, federal grants and grant-related requirements (in particular the requirements of and related to Section 330 of the Public Health Service Act) and nonprofit corporation law
- Counsel to National Association of Community Health Centers, and numerous Primary Care Associations and health centers nationwide for over 20 years
- Provides advice and technical assistance services on compliance with federal rules and requirements related to the operation, administration and governance of health centers and health center consortia; assists with development of federal grant applications; and analyzes and provides comments/advice on legislation, regulations and policies impacting health centers and the health care industry in general

PRESENTER: WARREN BRODINE

- President of W. J. Brodine & Co., working with health centers, PCAs, national associations, family planning centers/networks, other health care associations, and accountable care entities on program design and implementation, operations, finance and compliance
- Over 20 years in Community Health Center industry, including COO, CEO, and chief of strategy for three FQHCs, deputy director of a PCA, and work with a national consulting practice

PURPOSE OF SESSION & AGENDA

- Purpose: to explore the Operational Site Visit (OSV) process and some key “hot button” concerns along with “tips” for compliance
- Hot topics covered:
 - Program Requirements #10 & 11: Contracts and Collaborations
 - Program Requirement #17 & 18: Board Authorities and Composition
 - Program Requirements #7 & 13: Sliding Fee Discounts and Billing and Collection

INTRO TO PROGRAM REQUIREMENTS

- Programmatic requirements that apply to grantees, sub-grantees and FQHC Look-Alikes and that
 - Reflect the legal standards mandated by health center authorizing statute (Section 330 of the Public Health Service Act; 42 USC 254b) and implementing regulations (42 CFR Part 51c and Part 56 for Migrant Health Centers); and
 - Incorporate BPHC/HRSA policy positions
- Grouped into four categories that generally reflect the core components of the health center program: need, services, management & finance, governance

OPERATIONAL SITE VISIT 101

- On-site audit of a health center's compliance with 19 Health Center Program Requirements
 - 3-day OSV at least once per project period (generally mid project period)
 - Review team comprised of three HRSA consultants
 - Project Officer and/or other BPHC staff may be at the review to “observe” – health center may request presence of PCA representative as well
- Process designed to be objective
- No gray areas or “partial” compliance – center is either compliant or not compliant with each requirement at the time of the OSV

OPERATIONAL SITE VISIT 101

- Health Center Site Visit Guide = main (but not only) review instrument used by HRSA and its consultants to assess compliance with 19 Program Requirements
- Compliance sections divided into four main areas that mirror the four core components
- Each program requirement includes:
 - Legal authorities for each requirement
 - List of documents that will be assessed
 - Standardized, objective questions

OPERATIONAL SITE VISIT 101

- Site Visit Guide DOES NOT include performance improvement assessments for each requirement; reviewers can offer “recommendations” as long as they are not included in official compliance report
- Report is final and findings of non-compliance will result in grant conditions unless they are resolved during the on-site visit or prior to issuance of the report
- Average health center gets between 3-7 conditions
- Don’t “fight” compliance with program Requirements – there’s always room for improvement!

POTENTIAL CONSEQUENCES

- Special award conditions related to findings of non-compliance
- If significant number of conditions, or if conditions are unresolved within appropriate timeframes, may face:
 - Ineligibility to apply for certain expansion grants
 - One year project period for Service Area Competition (competitive project renewal)
 - “High-risk” designation
 - Cost disallowances
 - Draw-down restrictions
 - Suspension/termination of funding
- **Ultimately, could result in re-competition of your grant**

DRAFT COMPLIANCE MANUAL

- August 23, 2016: DRAFT Health Center Program Compliance Manual
 - Integrates some (not all) existing PINs and PALs
 - Provides guidance for demonstrating compliance with each requirement and examples of areas of discretion
 - Once final, will serve as consolidated resource
- Aligns credentialing/privileging requirements in PR #3 and quality improvement/assurance requirements in PR #8 with the FTCA deeming requirements
 - Adds additional requirements for Risk Management (applicable for FTCA deeming)

DRAFT COMPLIANCE MANUAL

- HRSA has indicated it will issue new OSV Protocol after the Manual is final
- **REMEMBER – PRESENTLY, THE MANUAL IS ONLY IN DRAFT FORM!**
 - Many changes may occur prior to being final
 - Not yet effective; should not be used during upcoming OSVs – reviewers have been instructed to use current guidance only
 - **HOWEVER**, advisable to read through before your OSV to see where HRSA is “headed” and to provide additional input into your preparations

HRSA LINKS

- Link to Program Requirements webpage:
<https://www.bphc.hrsa.gov/programrequirements/summary.html>
- Link to Site Visit Guide for health centers:
<https://www.bphc.hrsa.gov/programrequirements/sitevisitguide.html>
- Link to Compliance Manual webpage:
<https://www.bphc.hrsa.gov/programrequirements/draftcompliancemanual/index.html>
- Link to Scope of Project webpage:
<http://www.bphc.hrsa.gov/programrequirements/scope.html>

PROGRAM REQUIREMENT 2: SERVICES – REQUIREMENTS

- Must provide all required primary, preventive and enabling services
 - Directly, by established written contract / referral
 - Readily available and reasonably accessible to all patients equally and to all lifecycles of the target population(s)
 - Available regardless of an individual's or a family's ability to pay, **including discounted and nominal fees** (applies to in-scope referral arrangements – Form 5A, Column III)
- **Special population grantees – must provide (or arrange provision of) full service package PLUS additional services as required by statute**

PROGRAM REQUIREMENT 2: SERVICES – REQUIREMENTS

- Don't forget about after-hours coverage (Program Requirement #5) and hospitalization (Program Requirement #6)
- Services listed on Form 5A under Columns II and III (required AND additional) must be documented in a written contract or MOU that at a minimum includes all provisions listed in the Site Visit Guide (more on that in next section)

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – REQUIREMENTS

- Must make efforts to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center
- Must secure letter(s) of support from existing health centers in the service area or provide an explanation for why such letter(s) of support cannot be obtained

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – REQUIREMENTS

- Must maintain independence and compliance with all core requirements – arrangements with third parties
 - Cannot threaten or limit the health center's autonomy and/or integrity
 - Cannot compromise the health center's compliance with federal requirements, including procurement requirements
 - Must comply with HRSA affiliation policies, including establishing non-exclusive arrangements (can establish preferred partnerships if consistent with procurement rules)

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – REQUIREMENTS

- Sub-recipient agreements must have provisions that comply with the requirements of 45 C.F.R. Part 75:
 - Assurances in place that the sub-recipient complies with all statutory and regulatory requirements (including but not limited to 19 Program Requirements)
 - Provisions for monitoring by health center (including but not limited to on-site reviews) to ensure that the sub-award is used for authorized purposes and that the sub-recipient continues to maintain compliance

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – REQUIREMENTS

- Must have contract administration / management system consistent with 45 C.F.R. § 75.327(b)
 - Contractor's compliance with terms, conditions and specifications of the contract
 - Health center's monitoring and oversight of the contractor's performance and the contracted services provided to health center patients
 - Adequate and timely follow-up
 - Appropriate contract dispute provisions
- Must have and utilize board-approved policies that ensure appropriate procurements and otherwise comply with 45 CFR Part 75

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – REQUIREMENTS

In-Scope Contracts

- For compliance with Program Requirement #2 – must describe how:
 - Service will be documented in patient record
 - Health center will bill for service and provide payment to contractor
 - Health center's policies and procedures will apply to the contracted service
- For compliance with Program Requirement #7 – must describe how contracted services will be discounted consistent with the sliding fee discount rules and PIN 2014-02 (typically follows health center SFDS)

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – REQUIREMENTS

In-Scope Referrals

- For compliance with Program Requirement #2 – must be available equally to all patients, regardless of ability to pay
 - How the referral will be made and managed
 - Process for referring patients back to the health center for appropriate follow-up care
 - How the health center will track patients and provide follow-up care

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – REQUIREMENTS

In-Scope Referrals (cont.)

- For compliance with Program Requirement #7 – if sole access to an in-scope service is provided is through referral arrangement, it must be discounted for health center patients in accordance with a Sliding Fee Discount Schedule (SFDS)
- Referral provider's SFDS must
 - At a minimum, be as good as health center's discounts; referral provider can offer deeper discounts
 - Meet the “structural requirements” of and be applied consistent with PIN 2014-02
 - Be applied uniformly to similarly situated patients
 - Take into consideration patient access

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – TIPS

In-Scope Referrals: Additional Tips

- Health center may pay the referral provider the difference between the provider's charge and what the patients should pay under discount schedule
- Referral provider may be able to use its own charity care policies or those available under State law
 - Discounts apply equally to all individuals earning incomes at or below 200% Federal Poverty Level
 - MOU includes language indicating that the policy complies with Section 330 requirements and has been reviewed and approved by the health center

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS / COLLABORATIONS – TIPS

What Are Some Compliance Tips?

- Check State law for any limitations on HRSA approved FQHC arrangements
- Ensure that contracts and referral agreements include ALL requirements from the Health Center Site Visit Guide and procurement rules
- If “in-scope” additional/specialty services are provided only by referral and referral provider will not agree to sign MOU that includes the health center discount requirements, consider offering as an “informal referral” not listed on Form 5A
- Consider collaborating with all entities serving the same populations including non-health care support agencies, networks and programs

PROGRAM REQUIREMENTS 10 & 11: CONTRACTS AND COLLABORATIONS – HCH CONSIDERATIONS

- HCH-only programs – must still provide or arrange provision of all services to target population – contracts/referrals may be key
- Expect increased scrutiny as more of the program is contracted / referred versus provided directly, especially required enhanced substance abuse services
- Expect close inspection of how referrals are properly made and tracked, and documentation that clinical quality is assured
- Assurance of affordability, including full discount (or nominal) for persons with annual incomes at or below 100% of FPL
- Assure that all partnerships, including non-health care related collaborations, are appropriate and meaningful for patients

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES - REQUIREMENTS

Board must exercise proscribed authorities in statute, regulations, Site Visit Guide, PIN #2014-01: Health Center Program Governance and/or other HRSA guidance and policies

- Hold 12 regular monthly meetings and keep appropriate minutes demonstrating exercise of authorities
- Select, annually evaluate and as necessary, dismiss of the CEO
- Approve applications related to the health center project, including annual grant applications, Change in Scope applications, and other requests to HRSA
- Approve annual health center operating and capital budgets and accept / approve annual audit

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES - REQUIREMENTS

- Establish health care policies, including
 - Scope, availability and mode of delivery of services
 - Locations and hours of service provision
 - Quality of care audit policies and quality assurance/improvement plan

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES - REQUIREMENTS

- Establish general operating policies
 - Personnel policies (selection and dismissal policies; salary and benefit scales; employee grievance policy; equal opportunity practices)
 - Financial management practices (center priorities; fee schedules; sliding fee discount schedules; billing and collection policies; long-term financial planning; policies that assure accountability for health center resources)
 - Conflict of Interest Policy / Standards of Conduct

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES - REQUIREMENTS

- Conduct long-term strategic (3 years) planning, including update of mission, goals and plans as necessary and appropriate
- Measure and evaluate progress in meeting annual and long-term financial and programmatic goals
- Evaluate health center activities: service utilization patterns; productivity; patient satisfaction; achievement of project objectives; patient grievances

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES - TIPS

- Make sure that you can prove that the board properly exercises all prescribed authorities – remember, there is no partial compliance!
- Documentation should include board and committee meeting agendas and minutes, resolutions, board packet attachments (including management reports and presentations), work plans, strategic planning meeting notes, etc.
- For big issues, craft resolutions that include *why* an action is being taken rather than just taking votes to be recorded in the minutes (makes it easier to follow the board's decision-making)

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES - TIPS

- Key areas of scrutiny
 - QA/QI – does the full board approve the QA/QI plan, and receive regular information on QA/QI activities for oversight purposes?
 - Finance – does the full board approve/accept
 - Monthly financial statements, including variance between actual and budgeted revenues and expenses?
 - Annual budget, audit firm, and annual audit?
 - Form 990 prior to submission to IRS?
 - Appropriate executive compensation consistent with federal tax law and federal cost principles?
 - Salary and benefit scales (but not specific compensation packages) for other employees/positions?

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES - TIPS

- Develop plan for which policies must be approved by the board and the frequency of review and, as necessary, updated – when it happens
- Be prepared to discuss specific examples of key responsibilities exercised during the year
- Put in place process to review the Bylaws annually and ensure that the Bylaws are up to date and include all provisions specified in Health Center Site Visit Guide
- Have a board education program – demonstrates commitment to knowing the requirement

PROGRAM REQUIREMENT 17: BOARD AUTHORITIES – HCH CONSIDERATIONS

- **NO WAIVERS AVAILABLE FOR
MONTHLY MEETINGS OR
REQUIRED AUTHORITIES**

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - REQUIREMENTS

- Size of board must be between 9 – 25 members
- Patient board members must comprise at least the majority of the board and collectively, must reasonably represent patients in terms of demographic factors such as race, ethnicity and gender
 - Must be current registered patient who, within the past 2 years, has accessed one or more in-scope services that generated health center visit(s)
 - May be a legal guardian of a patient who is a dependent child or adult, or a legal sponsor of a patient who is an immigrant

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - REQUIREMENTS

- Non-patient board members must represent the community served by the health center and reflect a broad range of skills and expertise (consistent with regulatory requirements)
- No more than 1/2 of non-patient board members can earn more than 10% of income from health care industry
- For health centers receiving special population funds, appropriate special population representation (if receiving both special population and general community funding) or waivers (if receiving special population only funding) (see “Key Issues” slides)

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - TIPS

- Ensure that the board size complies with regulations and with the health center's Bylaws, and is appropriate for the size and complexity of center and diversity of community
- Ensure that all patient board members meet the current definition (presently, in governance PIN) at the time of the OSV
- “Reasonable representation” will depend on several factors including diversity of patient population and community – not a quota system
- Don't ignore the non-patient board member requirements – you must comply with those too!
- If non-patient board members do not live or work in the service area, document their connection to the community (*live/work was a standard relied on years ago*)

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - HCH CONSIDERATIONS

- If receiving both Section 330(e) and Section 330(h) funds, must have at least one HCH representative
 - Patient representative is advisable but not required
 - Can include advocate who has been a member of, has expertise or works closely with, or who otherwise represents HCH population (will not be included in patient-majority unless he/she is also patient)
 - Should continue efforts to recruit patient board members

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - HCH CONSIDERATIONS

- Can request waiver of consumer-majority if receiving 330(h) funds only
 - Not available if also receiving Section 330(e) funds
 - Not available for other governance provisions, including authorities (e.g., oversight of QI/QA, credentialing, hiring/evaluating/dismissing CEO, etc.) and monthly meetings
 - Two-step approach: (1) demonstrate good cause; and (2) present alternative strategies on how to meet the intent of the statute for ensuring patient participation in the organization, direction, and ongoing governance of the center

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - HCH CONSIDERATIONS

- Good cause – why the health center cannot meet the patient majority requirement
 - Based on unique or innate characteristics of the health center’s special population or service area that impose an undue hardship and/or pose a significant barrier to establishing a patient-majority board
 - Include description of attempts made to meet the requirement and why they were unsuccessful

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - HCH CONSIDERATIONS

- Alternative strategies for meaningful patient input into governance – plan must include
 - Description of alternative mechanism(s), including identification and qualifications of advisory board members, as applicable
 - Type of patient input to be collected and methods of collection and documentation
 - Process for formally communicating the input directly to the health center governing board
 - Specifics on how the governing board will consider patient input on (i) selecting health center services; (ii) setting health center operating hours; (iii) defining budget priorities; (iv) evaluating progress on the organization's goals (strategic plan), including patient satisfaction; and (v) other areas that benefit from direct patient input

PROGRAM REQUIREMENT 18: BOARD COMPOSITION - HCH CONSIDERATIONS

- Sample alternative strategies
 - Involvement of homeless patients on governing board (even if not majority)
 - Consumer advisory board that includes homeless patients, and that holds regular meetings and has real authority to share views with board in a formal way
 - Representatives from homeless-serving organizations with board seats
 - Significant participation in homeless organizations/coalitions
 - Continuous and regular seeking of patient feedback through focus groups, enhanced patient satisfaction surveys, patient interviews, other non-traditional patient feedback sources

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

General Application – Sliding Fee Discount Program (SFDP) Applies to ...

- All Section 330 grantees (including sub-recipients and special population only grantees) and FQHC look-alikes
- All patients served by the health center – **procedures can consider unique characteristics of populations**
- All in-scope services / service arrangements for which a charge has been established, regardless of type or mode of delivery i.e., all required and additional services listed on Form 5A in any column (I, II, and III)

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

Sliding Fee Discount Schedule (SFDS)

- Applies to all patients with incomes between 101% and 200% of Federal Poverty Level (FPL)
- Must have at least 3 discount pay classes above nominal fee tied to “gradations” in income level – can be % off charge master or flat fees
- Board must review/revise SFDS annually for compliance with current Federal Poverty Guidelines
- Board must assess effectiveness of the SFDS (annually) and the entire SFDP (once every three years) in reducing financial barriers to care)

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

Sliding Fee Discount Schedule (cont.)

- If using multiple SFDS (and nominal fees) for distinct types of services, sub-categories of services and/or modes of delivery, each one must meet the structural requirements (but can have different # of pay classes and/or different types of discounts)
- No regular discounts for patients with annual incomes above 200% FPL
- If receiving non-330 funds that require discounts above 200% FPL, may reduce patient payments accordingly

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

Nominal Fee

- Must provide a full discount to patients with annual incomes at or below 100% of the FPL; at most, can charge nominal fee
 - Flat fee that does not reflect the true cost of the service and that is considered nominal from patients' perspective
 - Must be less than lowest SFDS payment level
 - **Not** a payment threshold, minimum charge/fee or co-payment
- Board must evaluate annually whether nominal is “nominal from the patients’ perspectives” and not a barrier to care

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

Eligibility Verification

- Must have a system in place to determine eligibility for patient discounts adjusted on the basis of ability to pay
- Income and family size are the sole factors considered in determining eligibility – no net worth or asset tests
- For UDS purposes, must ask all patients about income and family size regardless of whether they are already on another public program (such as Medicaid) or are above 200% FPL
- All eligible patients must be offered opportunity to apply for discounts

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

Eligibility Verification (cont.)

- Board must define “income” and “family size” and necessary documentation
- Can (but not required to) use self-attestation as a form of “income documentation” – must be applied equally to similarly situated patients and must be included in board-approved SFDP policy
- Cannot require patient to apply and be turned down for insurance or related third party coverage before offering opportunity to apply for SFDP
- HOWEVER, if patient “opts out” of assessment or refuses to provide documentation (or as applicable, self-attestation), may charge him/her the full fee – should document in refusal in patient record

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

Eligibility Verification – Self Attestation

“Tips”

- Can be full (used broadly for anyone without formal income documentation) v. partial (only good for first visit) v. none
- Can be used for populations that due to unique characteristics may not have formal documentation (such as homeless patients)
- Attestation of income v. attestation of “no income”
- Include disclaimer on SFDP application and self-attestation (if any) that all information provided is truthful to the best of the patient's knowledge

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- REQUIREMENTS

Supplies and Equipment

- Service-related supplies and equipment related to the underlying service as part of the prevailing standard of care but charged separately (e.g., dentures, crowns, prescriptions drugs) can be discounted under a structure different from SFDS and nominal fee (such as cost recoupment)

Patient Co-Payments

- Not required to offer full slide to insured patients; however, if patient co-payment is more than he/she would have paid based on his/her SFDS pay class, at a minimum, must reduce co-payment to applicable SFDS pay class amount (subject to legal/contractual limitations)

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- TIPS

- Carefully review PIN 2014-02 and all of the questions posed in the Site Visit Guide ensure that all elements are addressed in your SFDP policy and procedure
- Secure board approval for entire SFDP
- Include explicit statement that no patients will be denied care due to inability to pay for services
- Train and prepare all management, staff and board members and coordinate implementation throughout the organization
- Ensure everyone is on the same page regarding how the SFDP is applied in practice (and make sure that what is on paper reflects what is being done)
- Update all patient materials / signage – must be clear and accurate AND visible to and understood by patients

PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS- HCH CONSIDERATIONS

- General policies to assess all patients, apply sliding fee discounts for individuals between 101% and 200% and apply full discount (or at most a nominal fee) must apply to all patients, regardless of whether they are homeless
- Must make some attempt to collect information relative to family size and income, even if only through self-attestation
- **Should not discount to zero automatically based on status of “homelessness” – persons may be “homeless” but working**
- May have different processes based on location – e.g., allowing longer-term self-attestation in shelter locations

PROGRAM REQUIREMENT 13: BILLING AND COLLECTIONS - REQUIREMENTS

General Billing and Collection

- Must have systems in place to maximize collections and reimbursement for costs of providing health services, including written billing, credit and collection policies and procedures
- Must make reasonable efforts to collect payments from public and private third party payers without application of discounts
- Must make reasonable efforts to bill and collect from patients in a manner that does not create a barrier to care

PROGRAM REQUIREMENT 13: BILLING AND COLLECTIONS - REQUIREMENTS

Waiver / Reductions of Payments

- Cannot deny services due to inability to pay for such services
- Must establish board-approved policies and procedures that identify circumstances to waive or reduce fees to ensure access (applies to all in-scope services)
 - Apply consistently and uniformly based on defined, board-approved circumstances with specified criteria (such as financial need that does not fit into the SFDS; unusual temporary circumstances that don't rise to the level of re-assessment of eligibility)
 - Define who has authority to make determinations and do not deviate (recommend by title not name)

PROGRAM REQUIREMENT 13: BILLING AND COLLECTIONS - TIPS

- Billing and collection policies and procedures cannot become a barrier to care or result in denial of care due to inability to pay
- “Reasonable efforts” to collect payments may vary based on elements unique to the health center and its patients
- Collection procedures can include:
 - Encouraging up-front payment at time of service as long as care is not denied
 - Follow-up letters and phone calls
 - Requiring patients with overdue balances to speak with financial counselor prior to next visit
 - Establishing grace periods and / or payment plans
 - Collection agencies (as long as barrier to care does not result)

PROGRAM REQUIREMENT 13: BILLING AND COLLECTIONS – HCH CONSIDERATIONS

- General policy to make reasonable efforts to collect from patients applies to all patients, regardless of whether they are homeless
- Must make some attempt to collect payments; however, may have different processes based on location – e.g., not collecting cash in outreach locations or homeless shelters
- While you may discharge a patient based on refusal to pay (unwillingness), you must be very careful in documenting how you discharge patients and what steps were taken. We do not recommend these policies unless absolutely necessary.

QUESTIONS??

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