Community Health Services and Prevention Divisions

Sliding Fee Discount Program, Services, Revenue, Billing and Collections Policies & Procedures

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HCHN Governance Council

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Objectives

- Oversight of standards for Revenue Cycle Management
  - Populations served
  - Registration and Insurance Assistance
  - Sliding Fee Discount Program and fee collection from patients
  - Billing Insurance
  - Posting Payments
  - Correcting, resubmitting, appealing claims

- Balance the financial sustainability of clinic operations with a strong commitment to eliminate barriers to care for homeless and other vulnerable individuals and families
Community Health Services and Prevention Division Roles

Business Practices – System management of client administrative processes
- Create and maintain standard work processes for client registration, scheduling, check-in/check-out activities
- Oversee compliance with Third Party Insurance coverage
- Oversee compliance with self-pay collection activities-Sliding Fee Discount Program
- Train all staff to standard work processes
- Develop and maintain curriculum around standard work processes

Central Business Office – Third Party Billing and Accounts Receivable
- Billing Analysts review, submit, correct, appeal claims
- Provider enrollment with third party payors
- Epic system design, build, test, fix
- Data analysis
Organizations Affected

Community Health Services and Prevention Division programs in 330h grant scope where:

• Client is registered in Epic and

• Services are billed through Epic (*no charge services/programs are not included*)
Oversight

• HCHN Governance Council
• PHSKC Division Directors
• PHSKC Compliance Unit
• OCHIN Oversight Committees (for system functionality)
Populations Served

In general, our target population are the most vulnerable residents of King County:

- Homeless

  Federally Qualified Health Center (FQHC)

  - Low income
  - State health insurance programs
  - Uninsured or Underinsured
  - Other: All seeking contraception, all seeking travel immunizations
Client Registration

The Client’s information is entered into the Practice Management System – EPIC

- Demographic data used for funding or supporting our programs:
  - Race, Ethnicity, Interpreter need, Homeless status, etc.

- Federal Poverty Level (FPL)
  - Family size & Household income-self-declared

- Insurance
  - Screening
  - Enrollment
Discount Fees for self-pay clients

- Based on **Federal Poverty Level (FPL)**: Calculated from Family Size & Household Income
  - Tiered Flat Fees ➔ Flat fee at each visit, regardless of services rendered
  - Sliding Fee Scale ➔ % discount based on services rendered

*NO CLIENT IS DENIED SERVICES DUE TO INABILITY TO PAY*
Sliding Fee Discount Program: Fee Evaluation

- PHSKC strives to remove barriers around access and maintain affordable services for all clients, especially our most vulnerable populations-including people experiencing homelessness.

- Our current fee structure has been in place since 2008 and we remain one of the most affordable Community Health Partners across the region.

- **Fee Calculation Formula:**

  Medicare RVU x Cost per RVU x % inflation

  or

  Market Rate

  (whichever is lower)
Fees Exceptions

- “A” status (at or under 100% of FPL) Homeless clients are not charged the Tiered Flat or Sliding Scale Fees

- No charges are assessed to clients receiving Parent Child Health (MSS/ICM) or WIC services

- **NO Discount** for Travel immunizations (only offered at the Downtown PHC)

*NO CLIENT IS DENIED SERVICES DUE TO INABILITY TO PAY*
Policy Components – Patient Fees

- Personal Health Services – Fees and Charges in BOH Code Title 3
- HRSA regulations – Sliding Fee Discount Scale

- Patient fees may be waived based on specific criteria
- Communicable disease control or emergency public health problem
- To remove barriers to accessing service (homelessness and behavioral health)
- Patient balances are written off as bad debt after 18 months
Client Payment Collections

- Clients are asked to pay their current fee amount as well as any outstanding balances from previous visits.

  Some charges may not be assessed at check-out (i.e. labs, radiology and supplies) resulting in outstanding balances.
Policy Components – Third Party Billing

• CMS Medicare and Washington State Medicaid billing rules

• HRSA regulations – Billing and Collections
  1. Claims are submitted within time frames specified by the payor (timely filing)
     o Check for Medicaid coverage on all uninsured clients
     o Denied claims are reviewed/corrected and resubmitted with the time frames specified by the payor
  2. Identified overpayments are reported and returned within 60 days of being identified
  3. Commercial Insurance
     o Do not bill insurance for confidential services including Family Planning, STD and behavioral health services for clients under the age of 18 or at a School Based Health Center
Third Party Billing Procedures

• Billing operational procedures for correcting claims, appeals, accounts receivable
  • Denial Procedures
  • Correcting, voiding, writing off charges
  • Replacement and Corrected Claims
  • Commercial Insurance
  • Credit balances
  • Refunds to clients or third party
Next Steps

- Minor updates to the Fee Ordinance with Board of Health
- Third Party Coverage Policy approval
- Annual review/update to Policies
  - Incorporate HRSA feedback
Questions?