Agenda Item Number:

ORANGE COUNTY BOARD OF HEALTH
AGENDA ITEM SUMMARY

Meeting Date: November 17, 2021

Agenda Item Subject: Policy Review - Fee & Eligibility Policy

Attachment(s): Section I.B. Fee and Eligibility Policy

Staff or Board Member Reporting: Micah Guindon

Purpose: ____ Action
_X_ Information only
____ Information with possible action

Summary Information:

FAS Division Director, Micah Guindon, will review recommended changes to the Fee and Eligibility Policy for the Department.

Recommended Action: _X_Approve
___Approve & forward to Board of Commissioners for action
___Approve & forward to _____
___Accept as information
___Revise & schedule for future action
___Other (detail):

Section I: **Board Adopted Policies**
Policy B: **Fee and Eligibility Policy**
Reviewed by: ~~Financial Review Committee~~Leadership Team, Health Director
Approved by: Board of Health, Health Director

I. Purpose

A. Public health services are increasingly costly to provide. The Health Department serves the public's interest best by assuring that all legally required public health services are furnished to all citizens. The department provides recommended and requested public health services based upon the priorities established by the Board of Health.

B. Fees are a means to help provide services to the residents of Orange County. Fees help finance and extend public health services when government funding is not sufficient to support the full cost of providing all required and requested services.

C. Fees for Orange County Health Department services are authorized under North Carolina G.S. 130A-39, provided that:
   1. They are in accordance with a plan recommended by the Health Director and approved by the Board of Health and the Orange County Board of Commissioners.
   2. They are not otherwise prohibited by law.
   3. They are deposited to the account of the local Health Department for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act.

D. Fees for services must also be in compliance with N.C. Administrative Code, Title X Regulations, and Women's and Children's Health Program Rules.

E. There will be no charge for Title X Services provided for individuals with income less than 100% of the Federal Poverty Level (FPL.)

II. Policy Implementation

The implementation of this policy is delegated to appropriate financial or support staff in each division of the health department.

III. Income Eligibility

A. Definitions

1. Definition: A family is defined as a group of 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. A pregnant woman is counted as a family of two in determining family size.

2. Income eligibility requirements apply to: Dental Health, Family Planning, Child Health, Maternal Health, Adult Health, Nutrition Services, Family Home Visiting, and Primary Care Services.

3. The Health Department utilizes a sliding fee scale based on Federal Poverty Guidelines in accordance with the Fee Schedule approved annually during the County Budget process. NC DPH updates and issues the scale yearly. Specifically,

Original Effective Date: January 25, 2001
Revision Dates:, 9/2015, 4/2016, 9/2018, 10/2019, 11/2021

the health department uses the 101% - 250% Federal Poverty Level sliding scale. Determination of Sliding Fee percentage is based on gross income and family size.

4. Verification of income is required at time of enrollment for services, at the annual financial interview, or if there is a change in the work status in the family unit for clients to be eligible for the sliding fee scale.
   a. An annual gross income statement is preferred for evaluation.
      i. Gross income is defined as the total of all cash income before deductions for income taxes, employee social security taxes, insurance premiums, bonds, etc. For self-employed applicants, net income after business expenses. Gross income does NOT include money earned by children for babysitting, lawn mowing and other tasks.
      ii. In general gross income includes: salary, wages, commissions, fees, tips, overtime pay, unemployment compensation, public assistance money, alimony and child support payments, Social Security benefits, VA benefits, Supplemental Security Income (SSI) benefits, retirement & pension payments, worker's compensation, bonuses, prize winnings and other sources of cash income except those specifically excluded.

B. Sources

1. Sources of income verification may include, but are not limited to:
   a. Current pay stub
   b. Self-employment accounting records
   c. Letter documenting current employment and wages from employer
   d. Recent income tax return
   e. Unemployment or workers compensation receipt
   f. Public assistance letter
   g. Prior income verification through enrollment in other Health Department programs
2. If an individual claims "no income" (except for minors consenting to specific services under G.S. 90-21.5), a signed "Verification of Income and/or Residency" form (Attachment A) indicating financial support from another party must be submitted.
3. Failure to provide verification within 30 days or less of date of service will result in charges being assessed at 100% of sliding fee scale. The client will receive notification of required income verification at the time the initial appointment is made.
4. The client must read, sign and understand the "Determination of Eligibility Payment Plan for Clinical Services" and "Statement of Financial Responsibility Payment Plan" form (Attachment B) at their initial visit and annual financial reviews.

C. Environmental Health

Persons seeking Environmental Health services must obtain and properly complete an application for service and pay the corresponding fee for service (all applicants pay at the 100% pay status) before an appointment for a field visit will be scheduled. Sometimes

additional fees may be necessary if during service delivery it is determined that the correct fees were not initially paid, or services requested are more than applied for. Wastewater Treatment Management Program (WTMP) and Mobile Home Park fees are the only Environmental Health services invoiced after the inspection. These inspections are not application based but occur on a regulated, recurring schedule.

IV. Residency Requirements

A. Any individual, Orange County resident or non-resident, may be eligible for services provided by the Health Department. Exceptions include non-STD Communicable Disease cases, designated Family Home Visiting programs (Orange County residents only), and when prohibited by law or regulation.

B. Proof of Residency may be determined by using the US Postal and/or Orange County GIS website and one of the following: Driver's License, Government-issued identification, Pay Stub (Within the last 30 days), Utility bill (Within the last 45 days); Current rental or lease agreement; Personal or property tax bill; Student identification, and Matrícula Consular (Mexican ID Card[1]). Clients without one of the above identifying information sources but reportedly living within the county will be required to produce a written statement or letter from the head of household, verifying that the person resides in their home. Special cases will be referred to the Clinic Manager or Supervisor. Failure to provide proof of residency may result in referral to another resource.

C. Proof of Residency in Orange County is required for self-pay patients to be eligible for the sliding fee scale when requesting Maternal Health, Child Health, Primary Care, Nutrition Services, and Dental Health Services. Out-of-county residents will be assessed at 100% of charges not covered by a third party payer source.

V. Service Limitation/Denial

A. Services will not be denied based solely on the inability to pay, with the exception of those services that require a flat or minimum fee. Emergency dental services and urgent primary care services will be provided to clients regardless of any outstanding balance due.

B. Otherwise, services may be denied if the department does not have the resources needed to provide a quality non-mandated service or the individual does not meet the residency or financial requirement.

[1] The **Matrícula Consular de Alta Seguridad (MCAS)** (**Consular Identification Card**) is an identification card issued by the Government of Mexico through its consulate offices to Mexican nationals residing outside of Mexico. Retrieved from http://en.wikipedia.org/wiki/Matr%C3%ADcula_Consular on October 14, 2012.

C. Family Planning, Maternal Health, and Child Health clients will never be refused service or be subject to variations in service due to an outstanding balance or inability to provide proof of income. Health Department clients are eligible to receive these services regardless of their participation in other programs. Family Planning, Maternal Health, and Child Health services are voluntary to all clients.

D. Falsification of eligibility by the client may result in denial or limitation of services.

E. The Health Department shall not deny a service due to religion, race, national origin, creed, sex, marital status, familial status, sexual orientation, veteran status or age.

F. The Health Department shall assure that no otherwise qualified handicapped individual, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity covered by this agreement.

G. The Health Director can override any decision to deny or limit services to a client in accordance with the existing fee waiver process.

VI. Fees for Services

A. In order to facilitate early entry into prenatal care or family planning services, pregnancy test charges will be adjusted to 0% on the sliding fee unless they are required as part of another service.

B. Fees are not charged to self-pay clients for diagnosis and treatment of sexually transmitted diseases, or investigation and control of communicable diseases. There is also no charge to clients for any State-provided vaccine.

C. Fees are charged for health and dental services provided to individuals unless prohibited by law or regulation. Fees are established based upon cost analysis, Medicaid and Medicare rates, comparable provider rates and/or state or contractual agreements. The Health Director shall inform the Board of Health and the Orange County Board of Commissioners of these adjustments in a timely manner.

D. Fees may be charged to clients for "non-program" specific services without being adjusted on a sliding fee scale (flat fees).

E. Fees may be charged for education, community-based limited clinical services (such as influenza shots) and screening services provided to individuals or groups. The following applies to these services:

1. They include orientation, field training, dental screening and education, and/or other health promotion activities such as infant and toddler car seats, bike helmets, or equipment rental.
2. The Health Director will negotiate fees for services where fees have not been previously determined.
3. Income eligibility requirements do not apply to these services.

F. Per NC General Statute Chapter 7B, Subchapter 4, Article 35, and confidentiality regulations, emancipated minors and other individuals requesting confidential services will be considered a family of one for determination of charges. Private insurance will also not be billed for minors receiving services for which they can consent unless permission is received from the minor.

G. Persons requesting any program services may be encouraged to apply for Medicaid, as applicable.

H. The Personal Health Services Division clinical and nutrition services will use the appropriate sliding fee schedule for services when adjustable fees are allowed; all other fees will be charged at 100%.
1. Clients, who require services provided on the sliding fee schedule, are expected to pay the appropriate fee in full based on sliding fee guidelines.
2. This schedule will require assessment of the client's financial status on an annual basis or when a financial status change occurs, as specified in section III.

I. Dental Health Services, Primary Care Services, and Nutrition Services will use a sliding fee schedule for all services, with a minimum charge to be established at the annual fee review during the budget preparation process.
1. The minimum charge for dental, primary care, and nutrition services will apply regardless of the determination of the client's financial status.
2. If a client is determined to fall at the 0% pay level, the minimum charge will be the only charge levied and collected unless the client is deemed homeless.
3. Minimum charge is due at time of service.

J. Fee schedules will be reviewed annually during the budget process and adjusted as appropriate; a complete cost analysis for purposes of fee adjustments will be performed every five years. The process for this cost analysis includes a review of the following elements:
a. Most recent vaccine and drug purchase costs
b. Most recent lab pricing lists
c. Most recent Medicaid Cost Settlement data for procedure costs
d. Environmental Health equipment, labor, and staff costs
e. Review of fee schedules of surrounding jurisdictions
f. Analysis of existing self-pay client base and how increased costs would affect their ability to get necessary care

K. Based on G.S. 130A-41, the Health Director is authorized to enter into contracts, which may include negotiated reimbursement rates.

L. The Health Director may not make exceptions to the Fee Policy except to accommodate specific situations through the fee waiver process (Attachment C).

M. Any minimum administrative fee or flat fees shall be applied without discrimination to all patients.

N. There will be no "schedule of donations", bills for donations, or any other implied coercion for donations from clients as a condition for being seen at the Health Department. Donations to the health department can be made through the Orange County Community Giving Fund. Fees for services will not be waived because of client donations.

O. Fees for 340b drugs dispensed to Medicaid patients will be reviewed and set annually based on the average, annual cost to the County to purchase the drugs.

VII. Fee Collection

A. Environmental Health service fees are paid before an appointment is scheduled. Field staff cannot accept fees in the field.

B. Fees collected from Medicaid and Medicare and other third party insurance for a covered service, combined with payment of any applicable co-pays and co-insurance, constitutes full payment for that service.

C. A co-payment, deductible, or balance of charge can be collected at the time of service from individuals covered by other third party insurance plans when OCHD is a member of their provider panel (exception family planning). For Family Planning clients, family income should be assessed before determining whether co-payments or additional fees are charged; if their family income is verified to be at or below 250% FPL, they should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied. With regard to other insured clients, payments towards a deductible for clients whose family income is verified to be at or below 250% FPL should have the appropriate sliding fee schedule applied.

D. If OCHD is not on the insurance provider panel, the client will be charged for the service(s) based on the Health Department's fee schedule. The client will be provided with documentation of services for submission of a claim to their insurance company.

E. After charges are processed, the client will be given a statement showing the cost of services for that visit as well as their total account balance upon request.

F. Payment is due at the time services are rendered.

G. When the client is unable to pay in full at the time services are rendered, a payment plan is established, and the client must sign a "Payment Agreement Form" (Attachment D) except for minimum-fee or flat-fee charges. Client must then make a payment in any amount in order to activate the payment plan.

H. When a client requests "no mail", discussion of payment of outstanding debt shall occur at the time the service is rendered. A remark regarding "no mail" is entered into the medical data system. No letters or other correspondence concerning insurance or past due accounts will be sent to any client that requests "no mail". Reasonable efforts will be made to collect charges without jeopardizing client confidentiality.

I. The Billing Cycle for the Health Department (by Division) is as follows:
   1. Personal Health Division
      a. Billing statements will be sent no more than three days after charges post to client ledger. Statements will be sent to clients for the next two consecutive months for balances due. After three consecutive months with a past due balance, accounts will be forwarded to the County Attorney Office and pursued through debt set-off in accordance with the county policy. Accounts with a balance of less than $50 will remain delinquent until paid or written-off.
   2. Dental Health Divisions
      a. Bill statements will be sent monthly by the tenth of the month for two months after services have been rendered indicating a statement of balance due. Every quarter, all accounts with a balance $50 or more that are more than 60 days past due will be forwarded to the County Attorney Office and pursued through debt set-off in accordance with the county policy. Accounts with a balance of less than $50 will remain delinquent until paid or written-off.
      b. If a debt is not paid, when the client attempts to make another appointment, the client will be told they have a previous balance, and they must have an active payment plan or make a payment at time of next service except for Family Planning clients.

   3. Environmental Health Division
      a. An initial invoice for additional or miscellaneous Wastewater Treatment Management Program (WTMP) charges is mailed with the inspection form.
      b. If no payment is received within 90 days, a second notice is mailed.
      c. If no payment is received after an additional 30 days and the debt is $50 or greater, the account is forwarded to the County Attorney's Office, which will pursue it through the county's debt set-off procedure.
      d. Debt owed by a corporation or non-individual is dissolved upon sale of property.
      e. The county attorney's office has deemed debt that becomes part of an estate will become dissolved.

f. If the client presents and voluntarily wishes to pay on the account, any amount the client offers will be accepted, documented in the client file, and a receipt will be provided.
g. Mobile Home Parks are billed annually on the calendar year. The procedure is the same as noted above.

J. Insurance and Third Party Billing
1. Where a third party is responsible, bills are to be submitted to that party;
2. Third parties authorized or legally obligated to pay for clients at or below 100% FPL are properly billed.
3. Third party bills (including Medicaid) show total charges without any discounts unless there is a contracted reimbursement rate that must be billed per the third party agreement.
4. The health department will bill insurance and managed care organizations for which provider approval has been established. The patient will be responsible for all deductibles, coinsurance and non-covered charges.
5. Patient or parent/guardian signature is required to give authorization to file claims and provide necessary information to the insurance company (Attachment E).
6. Patients, or the accompanying parent/guardian of an un-emancipated minor with appropriate insurance benefits, who receive public health services will be given the opportunity to choose whether to have insurance filed in order to avoid breach of confidentiality or pay the associated fee according to where the patient falls on the sliding fee scale.
~~6.~~7. If a third party denies the claim because a patient is not covered by the third party, the patient payment status is changed to self-pay. If the third party denies the claim because the claim was billed incorrectly, the Health Department corrects the error and resubmits the claim.

VIII. Review and Approval

A. This Policy shall be reviewed annually by members of the ~~Financial Review Committee~~Leadership Team. The committee shall have representatives from each division, and must also include the Health Department's Finance and Administrative Services Director

B. Any policy revisions must be approved by the Health Director and the Board of Health.