TITLE: Discount Program Policy		POLICY No.
ADOPTED: 10/30/2009	REVISED: 05/12/2020	
DISTRIBUTION:		
REVIEWED BY: Executive team, Reimbursement Supervisor		
APPROVED BY: Board of Directors		

Policy and Procedure: Salina Family Healthcare Center (SFHC) receives federal grant funds to assist qualifying individuals in obtaining medical/dental care. SFHC **is not** a free clinic. Any services received at another office/hospital or by referral are **not** subject to the Discount Program. Charges for services received will be based on a client's ability to pay. This will be determined by using Federal Poverty Level Guidelines that are published annually in the Federal Register. These regulations will form the basis for the Discount Program Discount Schedule. The Discount Schedule may be updated upon publication of the Federal Poverty Guidelines, if necessary, then taken to the next regularly scheduled meeting of the Board of Directors for approval.

Screening

Financial screening for the Discount Program will occur by appointment. Appointments will be scheduled 15 minutes apart, total number depending on our hours of operation. Previously dismissed patients are ineligible to apply for the Discount Program until they have completed the reinstatement process. Clients must bring income documentation as requested by Salina Family Healthcare Center in order to qualify for the Discount Program. The patient will fill out a *Discount Program Application Form.* If the patient does not have all information needed they will be given a *Missing Information Letter* by the screener. SFHC will make a reasonable effort to provide a one month card to those missing information to allow time for the necessary information (i.e. worker's compensation, pensions, veteran's benefits, unemployment, student loans, ID, birth certificates, denial letters, etc.) to be provided. All information is required in order to screen for a 6 month card.

"Household" is defined as all family members living at the same address.
"Family members" is defined as relatives by blood or those by marriage legally entered into in a U.S. jurisdiction that recognizes their marriage.

All applications will be reviewed by the Financial Screener after the screening is concluded (before eligibility/level is declared to the patient).

Items needed to financial screen include:

- Proof of income for all household members:

SRS Programs	Worker's Compensation	Social Security	Veteran's Benefits
Self-employment	Pensions	Retirement	Unemployment
SSI	Child Support	Alimony	Student Loans (with proof of amount payable directly to the applicant)

- Complete and current tax return (including all schedules)if filed;
- The last 3 months proof of self-employment income or at least 1-month worth of current paycheck stubs (including overtime) for all family members in the household;
- Photo ID or birth certificate for all family members in the household;
- Denial letter from SRS for Medicaid if pregnant or under 19 (exceptions may be made for college students unlikely to qualify for a Medicaid card).

Check Stubs –

- Staff will ensure that the patient has not been paying for health/dental insurance out of pay. This will act as an internal verification system of non-insurance for the patient.
- If the paycheck stub indicates the employee may have health/dental insurance, staff will verify with the employer of the patient to confirm whether any family members are enrolled with patient and/or what is covered by carrier.
- Paycheck stub should contain gross pay, pay period beginning and ending date as well as pay date. This will aide in telling us how often the patient is paid.

Original and current proof of residence will need to be given to the Financial Screener for all patients living at temporary crisis housing facilities (i.e. Ashby House, Salina Rescue Mission, CKF, etc.).

Department Specific

The Billing Department will conduct a second review of the screening paperwork to determine the level of eligibility. The insurance field in the Practice Management and Pharmacy systems will be updated with the appropriate level of discount by the Billing Department within three (3) business days, excluding Saturday. All screening paperwork is then sent for creation of the discount card.

Billing will scan all paperwork into the Practice Management System, and then it is to be filed. The Discount Program Card and packet, appropriate to the level at which the patient screened, will be mailed to the patient generally within one week of screening. *See* following New Patients section for further information regarding mailing of cards.

Hospital Follow-Up Appointments

Salina Regional Health Center may refer patients to our office that do not have insurance for a hospital follow-up appointment; when this occurs the Front Desk staff will schedule the appointment and make a 30 day, to begin on date of discharge, Level B card to give to the patient at their appointment. In the event that the patient should DNKA a screening appointment(s), this benefit will be limited at two per lifetime.

Special Circumstances

If the household has no income, the patient shall provide a notarized proof of support letter from whoever is providing support to the patient. If the patient has no income and is living with a non-relative, a notarized letter of support is needed. However, if this documentation is written and signed during the screening appointment it may be witnessed by two SFHC employees in lieu of being notarized. For services provided on the same day as financial screening, this documentation must be received by the end of the following business day for the services to be considered for discount. If a screener is not available, "no screener" will be noted in the reason and the patient will be scheduled with financial screening within two (2) business days – all documentation must still be provided by the end of the business day following the screening appointment. Without this documentation, clients will be charged the full fee for services received.

Clients without a third-party payer will be asked to pay for services at the time of service. Should they be unable to pay the full amount, a payment plan may be required. The full fee will be charged to all clients who have a household income over 200% of the federal poverty guidelines.

Persons who did not file a tax return for the preceding year will be required to complete a *Missing Tax Return Form*. For reasons other than not having a social security number, a non-filer will be required to complete a 4506 T for possible confirmation of non-filing.

In the event that a Federal, State, or local public health emergency or a natural disaster emergency is declared, the expiration date of purple cards will be extended for an appropriate amount of time based on the nature of the emergency. SFHC will complete virtual (phone or email) screenings to accommodate patients, if possible. The self-declare option may be broadened for self-pay patients with scheduled appointments during the emergency. The Reimbursement Supervisor will be responsible for record keeping of the nature of the event, timelines and the organization's temporary measures to facilitate patient screening under this policy.

Balances Due

If a patient wishes to schedule a screening or a re-screening appointment and has a balance at SFHC, SFHC shall make a genuine attempt at collecting the balance due from the patient. Our practice management system will identify those individuals with outstanding balances. If a patient has a balance at the time of check-in for the screening or re-screening appointment, they will be asked to pay the balance. However, if the patient is unable to do so at that time, SFHC will ask for a minimum of 50% of the total account balance or $100, whichever is more, and the patient will be asked to sign a *Payment Arrangement Letter* stating the amount and date(s) they may make payments. ***The Length of coverage on the Discount Program may be reduced, to ensure payment arrangements are kept or to verify income levels or insurance coverage status.***

There are times when a current patient has an old balance (over 90 days) or large balance (over $500). If a patient has an old or large account and cannot make a payment that day, a *Payment Arrangement Letter* may be filled out. When patients fail to keep payment arrangements they may be allowed an appointment on a walk-in basis and may be subject to triage by nursing staff if they are unable to pay their co-pay and/or make payment on their balance. The appointment cost will be added to the patient's balance.

Discount Program Specifics

Discount Program cards will be given to those eligible patients who complete their financial screening and qualify under Federal Poverty Level Guidelines as published by the Federal Register. Cards are given for a maximum of six (6) months and will be given at levels B, C, D and E. The information in our Practice Management System will be used to settle conflicts related to a patient's Discount Program status. If a patient re-screens which results in a change in their level but had a service that is processed at their prior level that had not expired there will not be an adjustment to the patient's account.

The Discount Program is available to those individuals who have insurance but the policy does not cover a particular problem/diagnosis for which the patient is being seen. The Discount Program is only available to the individual for that non-covered service. However, screening for pharmacy only is not permitted. A copy of the policy will be requested from the patient to verify non-coverage. Waiting periods do not qualify as having no health coverage unless there is an emergent situation. This will be evaluated on a case by case basis and approved by a member of the executive team (the Chief Executive Officer, the Chief Financial Officer, the Chief Medical Officer, the Chief Operations Officer, the Chief Compliance Officer or Program Director).

The Discount Program is available for non-covered dental services, non-covered prescriptions, and non-340b eligible prescriptions to patients who have Medicaid. A presumptive qualification for level B discounts applies to non-covered dental services, non-covered prescriptions (excluding controlled drugs),and non-340b eligible prescriptions (excluding controlled drugs) under the patient's Medicaid plan based on the patient meeting Medicaid income guidelines, which generally align with the Discount Program level B category, and approval for Medicaid coverage.

The Discount Program is available to those individuals who have insurance coverage with a carrier that SFHC has unsuccessfully attempted to contract with for reimbursement (e.g., out of state Medicaid plans). The Reimbursement Supervisor will maintain the list of these insurance carriers.

Patients having a dental rider may screen to determine eligibility for reduced fees for dental care.

Co-pays

Baseline co-pays will be determined annually. A minimum fee will be assessed on most services. Minimum fees will not apply to select services. Patients will be asked to pay nominal fees in accordance with the current fee schedule at the time of service in either the medical or dental clinic. When a payment is received, the account is credited and a receipt is given. If a patient states they are unable to pay the co-pay for their visit, the service may be postponed until a later date and/or the patient may be directed to our billing department to sign a *Payment Arrangement Letter*.

Re-Screening

Eligibility is re-evaluated as needed or requested by patient. The patient is required to complete a new discount program application and bring all information needed to apply. Reminder calls are sent out via EMR call campaign the month prior to patient's card expiring whenever possible.

New Patients

If a new patient presents to the medical/dental office(s) for emergent care and does not have insurance, the patient will be asked to pay 100% of the charges but any good faith payment will be accepted. Dental will ask for 100% payment, or the appointment may be rescheduled as appropriate for that day. The patient will be entered into the insurance field (medical/dental) and will be charged 100% if the patient does not have any income verification with them at that time. If the patient comes back within 1 business day with income verification, SFHC will date the card to cover the appropriate service.

If a new patient presents to the medical/dental office(s) for a financial screening and has all necessary paperwork, the screener will verify whether or not they are a current patient at either office. A patient is defined as one who has been seen by a provider within the past twelve (12) months. For non-current/new patients, Front Desk staff will send a letter to the non-current/new patient indicating qualification for the program and will update the card information in the Alpha Card System. When the patient presents to the medical or dental office for their initial visit, a card is created and scanned into their cash plan section in the medical practice management system. In the event the patient does not establish care at either office within the active dates of the Discount Program card, no card is created and the cash plan policy is expired automatically by the system.

A new patient at the time of their first visit may self-declare by completing the household size and income portion of the patient registration form. This will mirror the urgent care self-declare process outlined below. Discount level H, I, J or K will be utilized for new patient's that have self-declared as well.

Unestablished Urgent Care Discounts

Unestablished patients with an urgent care appointment in the SFHC medical clinic or an emergent care in the SFHC dental clinic may receive discounted services if they are uninsured. The patient must not have been previously seen at SFHC for the services (medical or dental) sought.

The household size and income information the patient writes on the Registration Form will be used to determine the discount level (H, I, J, or K). If the patient has provided an income range that spans two discount levels, the patient will be assigned the level that provides the greatest discount to them. Patients above 200% of the federal poverty guidelines will not receive a discount.

The urgent care self-declared discount is only available one time at the first visit in medical and the first visit in dental (per the current EMR) at SFHC. The urgent care self-declared discount is not available to patients after their initial visit regardless of if they accessed the discount for that visit or not. They would be able to same day screen under the purple card program. Patients who do not have a primary care provider will then be offered a financial screening appointment and provided information about the program.

Front desk staff will complete the insurance set-up for the appropriate level (H, I, J, or K) with both the start and termination date the same as the date of service before the patient check-in is complete.

If a patient qualifies for the urgent care self-declared discount, they will be given a yellow slip at check-in to take to the pharmacy. Patients must present the yellow slip to the pharmacy to receive the discount. If the slip is not presented by the patient at the time the prescription is picked up, the prescription will not be reprocessed at the self-declared discount level.

Missing Information

If a patient presents to the medical/dental office(s) for a financial screening, and does not have a medical/dental appointment that day, the patient will be considered self-pay until all information is provided. The patient may receive a M*issing Information Letter* which will serve as a reminder to the patient to bring in the missing information. All information provided for the screening will be given back to the patient and the screening appointment will be rescheduled.

If a patient presents to the medical/dental office(s) for a financial screening, and has an appointment for that day, but does not have all needed information to screen, self-pay will be entered into the insurance field (medical/dental) and the patient will be charged 100% of the visit. If the patient comes back within 1 business day with income verification, SFHC will date the card to cover the appropriate service.

Non-Compliance

If it comes to our staff's attention that an individual is not in compliance with the system, SFHC will issue a *Health Coverage Notice Letter* stating that the patient must bring in their insurance card to their next appointment for our records or they will then be considered self-pay and that we will continue to provide them healthcare and/or dental services but future services through our Discount Program may not be allowed for one year.

Other

In the event a patient presents with circumstances not addressed in this policy, a determination will be made by the Reimbursement Supervisor and/or the Chief Compliance Officer. If further review is necessary, final determination is at the discretion of the Chief Executive Officer.

Salina Family Healthcare Center
Discount Program Fees
Effective May 26, 2020

Office Visit / Nursing Home Visit/BH Medication Management	Level B/H	Level C/I	Level D/J	Level E/K	Medicare B	Medicare C	Medicare D	Medicare E
Office, Nursing Home, BH Medication Management	$ 30.00	$ 45.00	$ 70.00	$ 95.00	$ 10.00	$ 12.00	$ 14.00	$ 16.00
Nursing Visit	$ 10.00	$ 12.00	$ 14.00	$ 16.00	$ 10.00	$ 12.00	$ 14.00	$ 16.00

* Includes: Lab Levels I, II & Send out; Radiology/EKG; Minimal Procedures; and Testing performed at the time of the visit
* Other charges may apply (i.e. vaccines, high cost labs, DME, IM medication, other visits/services on the same day, etc.)
* Lab and radiology ordered during the visit but not completed at the time of the visit (i.e. patient not able to provide sample, fasting labs, etc.) will be charged separately
* Orders and/or referrals to outside providers may result in additional charges

Procedures/Testing	Level B/H	Level C/I	Level D/J	Level E/K	Medicare B	Medicare C	Medicare D	Medicare E
Testing	$ 10.00	$ 12.00	$ 14.00	$ 16.00	$ 10.00	$ 12.00	$ 14.00	$ 16.00
Minimal	$ 10.00	$ 12.00	$ 14.00	$ 16.00	$ 10.00	$ 12.00	$ 14.00	$ 16.00
Low	$ 30.00	$ 35.00	$ 40.00	$ 45.00	$ 20.00	$ 22.00	$ 24.00	$ 25.00
Basic	$ 50.00	$ 55.00	$ 90.00	$ 155.00	$ 20.00	$ 22.00	$ 24.00	$ 25.00
Moderate	$ 100.00	$ 110.00	$ 180.00	$ 210.00	$ 20.00	$ 22.00	$ 24.00	$ 25.00
Complex	$ 150.00	$ 165.00	$ 270.00	$ 465.00	$ 20.00	$ 22.00	$ 24.00	$ 25.00

* Other charges may apply (i.e. implantable contraception, Synvisc, DME, medication, etc. if not provided by another program/agency)

OB Care	Level B	Level C	Level D	Level E
	$ 200.00	$ 400.00	$ 600.00	$ 800.00

* Includes prenatal and antepartum visits and initial OB lab profile. Other charges may apply (i.e. additional labs, hospital days, procedures).
* Includes Group B Strep Culture in 3rd trimester.
* Labs ordered and/or completed at the time of routine OB visits other than the OB lab profile and Group B Strep Culture will be charged at the Lab Only rates.

Behavioral Health/Chronic Care Management/Clinical Pharmacist	Level B	Level C	Level D	Level E	Medicare B	Medicare C	Medicare D	Medicare E
	$ 10.00	$ 12.00	$ 14.00	$ 16.00	$ 10.00	$ 12.00	$ 14.00	$ 16.00

Lab/Radiology/EKG	Level B/H	Level C/I	Level D/J	Level E/K	Medicare B	Medicare C	Medicare D	Medicare E
Draw Fee	$ 5.00	$ 6.00	$ 7.00	$ 8.00	$ -	$ -	$ -	$ -
Lab - Level I	$ 5.00	$ 6.00	$ 7.00	$ 8.00				
Lab - Level II	$ 10.00	$ 12.00	$ 15.00	$ 20.00				
Lab - Level III	$ 40.00	$ 60.00	$ 80.00	$ 100.00				
Radiology/EKG - per study	$ 35.00	$ 36.00	$ 37.00	$ 38.00	$ 3.00	$ 4.00	$ 5.00	$ 6.00

* Level B/H send out labs are no charge to patient. Patient is charged the Draw Fee.

Hospital Care/ER	Level B	Level C	Level D	Level E	Medicare B	Medicare C	Medicare D	Medicare E
Hospital & ER - Level I	$ 10.00	$ 20.00	$ 25.00	$ 30.00	$ 14.00	$ 16.00	$ 18.00	$ 20.00
ER - Level II	$ 50.00	$ 65.00	$ 90.00	$ 115.00	$ 15.00	$ 20.00	$ 25.00	$ 30.00

* Includes observation days, in-patient care, rehab, swing bed, etc.
* Patients with procedures performed in the hospital will also incur the above listed procedure fee

Additional Information:

Staff use only - not for distribution to patients

Vaccines

* Uninsured patients under age 19 - no charge when using VFC

* Uninsured patients 19 and older - no charge for administration, vaccine charged to patient if not provided/covered by manufacturer or pharmacy program

Durable Medical Equipment (DME)

* Excluded from above discounts. Charges are billed to the patient.

Multiple Visit Types on Same Day

* If a patient has multiple appointments on the same day, they will be charged for each visit. Examples:

1. Office visit on the same day as a behavioral health visit

2. Patient has a lab appointment in the morning and an office visit in the afternoon
Patient will be responsible for labs using the lab only schedule in the morning and the office visit charge in the afternoon

* If an office visit for a particular concern results in a procedure being performed, the patient will be responsible for the higher visit type charge or multiple visit charges. Examples:

1. Office visit scheduled for knee pain results in an injection, patient will be responsible for procedure charge assuming this is the only concern addressed during the visit.

2. During an office visit scheduled for hypertension f/u the provider and patient also discuss knee pain and provider performs an injection.

Patient will be responsible for both an office visit charge (hypertension) and a procedure charge (knee pain/injection).

3. During routine OB visit the patient is also evaluated and treated for a sinus infection.
Patient will be responsible for an office visit charge for the day related to the sinus infection.