C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

BOARD OF DIRECTORS
March 12, 2021
12:00 P.M.

Meeting Location
1515 N. Flagler Drive, Suite 101
West Palm Beach, FL 33401

If a person decides to appeal any decision made by the board, with respect to any matter at such meeting or hearing, he will need a record of the proceedings, and that, for such purpose, he may need to ensure that a verbatim record of the proceedings made, which record includes the testimony and evidence upon which the appeal is to be based.

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

BOARD OF DIRECTORS MEETING
AGENDA
MARCH 12, 2021
1515 N. Flagler Drive, Suite 101
West Palm Beach, FL 33401

Remote Participation Login: https://tinyurl.com/yda3vnks

or

DIAL +1 (646) 558 8656; Meeting ID: 550 789 5592; Access number: 946503

1. Call to Order – Mike Smith, Chair

A. Roll Call

B. Affirmation of Mission: To provide compassionate, comprehensive health services to all Palm Beach County residents, through collaboration and partnership, in a culturally sensitive environment.

2. Agenda Approval

A. Additions/Deletions/Substitutions

B. Motion to Approve Agenda

3. Awards, Introductions and Presentations

4. Disclosure of Voting Conflict

5. Public Comment*

6. Meeting Minutes

7. Consent Agenda – Motion to Approve Consent Agenda Items

All matters listed under this item are considered routine and action will be taken by one motion. There will be no separate discussion of these items unless a Commissioner or person so requests, in which the item will be removed from the general order of business and considered on its normal sequence on the Agenda.

A. ADMINISTRATION

7A-1 **RECEIVE AND FILE:**
March 2021 Internet Posting of District Public Meeting
https://www.hcdpbc.org/resources/public-meetings

7A-2 **RECEIVE AND FILE:**
Attendance tracking [Page 1]

8. Regular Agenda

A. ADMINISTRATION

8A-1 **Staff recommends a MOTION TO APPROVE:**
Billing & Collection Policies
(Candice Abbott) [Pages 2-27]

8A-2 **Staff recommends a MOTION TO APPROVE:**
Change in Scope – North County PBG
(Dr. Hyla Fritsch) [Pages 28-29]

8A-3 **Staff recommends a MOTION TO APPROVE:**
Compliance with HRSA Monthly Meeting Requirement
(Dr. Hyla Fritsch) [Pages 30-36]

9. AVP and Executive Director of Clinic Services Comments

10. Board Member Comments

11. Establishment of Upcoming Meetings

March 31, 2021 (HCD Board Room)
12:45pm Board of Directors

April 28, 2021 (HCD Board Room)
12:45pm Board of Directors

May 26, 2021 (HCD Board Room)
12:45pm Board of Directors

June 30, 2021 (HCD Board Room)
12:45pm Board of Directors

July 28, 2021 (HCD Board Room)
12:45pm Board of Directors

August 25, 2021 (HCD Board Room)
12:45pm Board of Directors

September 29, 2021 (HCD Board Room)
12:45pm Board of Directors

October 27, 2021 (HCD Board Room)
12:45pm Board of Directors

11. Establishment of Upcoming Meetings (Cont'd)

November 30, 2021 (HCD Board Room)
12:45pm Board of Directors

December 14, 2021 (HCD Board Room)
12:45pm Board of Directors

13. Motion to Adjourn

*District Clinic Holdings, Inc. welcomes public comment during its regular monthly meetings. This month, public comment should be emailed to swynn@hcdpbc.org or submitted via phone 561-829-1211 prior to Noon on The Scheduled Meeting Date. All comments received during this time frame will be read aloud and included in the official meeting record.

Any person(s) not adhering to the Board's guidelines or who make comments which could be perceived as slanderous or disruptive may be barred from making future comments before the Board.

C. L. Brumback Primary Care Clinics
Board of Directors

Attendance Tracking

	1/27/21	2/24/21	3/12/21	3/31/21	4/28/21	5/26/21	6/30/21	7/28/21	8/25/21	9/29/21	10/27/21	11/30/21	12/15/21
Mike Smith	X	X											
James Elder	X	X											
Irene Figueroa	X	E											
John Casey Mullen	X	X											
Julia Bullard	X	X											
Marjorie Etienne	E	E											
Melissa Mastrangelo	E	A											
Tammy Jackson-Moore	X	X											
Robert Glass		X											

X= Present

C= Cancel

E= Excused

A= Absent

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
March 12, 2021

1. Description: Billing & Collection Policies

2. Summary:

This agenda item provides the C. L. Brumback Primary Care Clinics Billing and Collection Policies for review and approve.

3. Substantive Analysis:

Per Chapter 19 of the HRSA Compliance Manual, the Health Center Board must review the following at least once every three years, and, as needed, approve updates to policies in the following areas: Sliding Fee Discount Program, Quality Improvement/Assurance, and Billing and Collections. Policies related to billing and collections that require Board approval include those that address the waiving or reducing of amounts owed by patients due to inability to pay, and if applicable those that limit or deny services due to refusal to pay.

Please see the following attached Billing and Collection policies for your review and re-approval:

- Account Receivable – 502-13
- Advance Beneficiary Notice – 517-16
- Auditing and Monitoring – 505-16
- Care Transitions – RCQ-001a
- Charge Capture & Reconciliation – 514-16
- Claims Submission – 515-16
- Coding Documentation – 508-16
- Collections – 509-16
- Incident to Billing – 516-16
- Medical Necessity – 507-16
- Medical Record Documentation – 513-16
- Patient Payment – 511-15
- Petty Cash – 519-17
- Sliding Fee Discount Program – 501-13
- Training – 510-16
- Waiver of Fees – 522-19

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	**N/A**	Yes ☐ No ☒
Annual Net Revenue	**N/A**	Yes ☐ No ☒
Annual Expenditures	**N/A**	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

Tony Colby
Interim VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A
Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board Approve the Billing and Collection Policies.

Approved for Legal sufficiency:

Christy Goddeau
Acting General Counsel

Candice Abbott
VP & Chief Clinical Integration Officer

Dr. Hyla Fritsch
AVP, Executive Director of Clinic
& Pharmacy Services

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Accounts Receivable Policy

Policy #:	502-13	Effective Date:	12/6/2013
Business Unit:	Primary Care Clinics	Last Review Date:	02/26/2020
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	12/06/2013		

SCOPE

This Financial Policy outlines requirements for the accounting and management of accounts receivable (AR) transactions within the clinical operations utilizing Electronic Health Record (EHR). It also establishes uniform guidelines and principles in regards to billing, collections, and write-off of accounts receivables.

POLICY

The AR Policy is to provide consistency by following standard best practices that follow general accounting principles related to revenue cycle management. This includes:

- Properly charge and bill responsible payor's.
- Collect from all Third Party entities in a timely manner.
- Collect from clients that have the ability to pay in a timely manner.
- Provide a recourse collections process on clients with delinquent accounts that have the ability to pay.

EXCEPTIONS

N/A

C. L. Brumback
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Health Care District Palm Beach County

RELATED DOCUMENTS	
Related Policy Document(s)	502-13-A
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

The master document is controlled electronically. Printed copies of this document are not controlled. Document users are responsible for ensuring printed copies are valid prior to use.

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Advance Beneficiary Notice

Policy #:	517-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to obtain an Advance Beneficiary Notice (ABN) from Medicare beneficiaries when tests/services may not be covered according to Local Medical Review Policy (LMRP) or National Coverage Limitations or other criteria issued by Medicare or the Medicare Carrier.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Auditing and Monitoring Policy

Policy #:	505-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to audit and monitor its billing functions as part of its compliance program to ensure that billing practices are consistent with applicable federal, state and local laws and sound ethical business practices.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
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Health Care District Palm Beach County

Quality Care Transitions Policy

Policy #:	RCQ-001a	Effective Date:	1/1/2020
Business Unit:	Primary Care Clinics	Last Review Date:	2/21/2020
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Revenue Cycle
Board Approval Date:	3/25/2020		

PURPOSE

To establish a policy for coordinating patient care during and after transitions from acute care settings.

SCOPE

This procedure is applicable to all team-members who are involved in care transitions in the revenue cycle department.

POLICY

The Health Care District of Palm Beach County works with health plans and C.L Brumback Clinics to systematically identify patients with unplanned hospital admissions and emergency department visits and performs post-hospital/ED visit follow-up through the contact of patients/families/caregivers for follow-up care, if needed, within 48 hours.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	RCQ-001b
Reference(s)	RCQ-001b
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Charge Capture and Reconciliation Policy

Policy #:	514-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to maintain patient records which accurately and fairly reflect the treatment and services rendered, consistent with applicable federal and state laws and regulations. All health care providers are required to document in the medical record pertinent facts, findings and observations about a patient's health history, including past, and present illness, examinations, tests, treatments, and outcomes.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Claims Submission Policy

Policy #:	515-16	Effective Date:	8/30/2019
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to submit all claims promptly according to guidelines established by each carrier.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Coding Documentation Policy

Policy #:	508-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/14/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016, 12/10/2019		

POLICY

It is clinic operations policy to ensure the accuracy, integrity and quality of patient data, and improve the quality of medical record documentation to reflect the assignment of billing codes. Coding is performed consistent with the Current Procedural Terminology (CPT) coding conventions and guidelines published by the American Medical Association as well as requirements of private insurance carriers regarding ICD-10-CM. Coding for Medicare services are performed according to CPT and Level I and II HCPCS codes and Level III HCPCS codes of Medicare's fiscal intermediary.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Collections Policy

Policy #:	509-16	Effective Date:	6/28/2017
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to collect all balances due from patients fairly and equitably and in a manner consistent with applicable laws and rules from Medicare and private insurance carriers.

The clinic operations will serve anyone regardless of their ability to pay.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Incident to Billing Policy

Policy #:	516-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to ensure that payers are appropriately billed for services/supplies furnished by ancillary staff (i.e., nurse, medical assistant, technician, etc.) and non-physician practitioners licensed to practice under state law (such as physician assistants, nurse practitioners and certified registered nurse anesthetists) when they are provided "incident to" a physician's service, consistent with federal and state law and regulations and payer requirements.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Medical Necessity Policy

Policy #:	507-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to order only those tests and/or services that clinical providers believe are medically necessary for the diagnosis and treatment of their patients. A specific diagnosis, sign, symptom, disease and/or ICD-10-CM code must be provided for each test and/or service ordered to appropriately reflect medical necessity.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Medical Record Documentation Policy

Policy #:	513-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/04/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to maintain patient records which accurately and fairly reflect the treatment and services rendered, consistent with applicable federal and state laws and regulations. Health care providers involved in rendering care to the patient are required to document in the medical record pertinent facts, findings and observations about a patient's health history, including past, and present illness, examinations, tests, treatments, and outcomes.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Patient Payment Policy

Policy #:	511-15	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/06/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016, 12/10/2019		

POLICY

It is clinic operations policy to collect patient payments promptly and equitably, consistent with all federal, state and payer regulations.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Petty Cash Policy

Policy #:	519-17	Effective Date:	5/24/2017
Business Unit:	Primary Care Clinics	Last Review Date:	11/4/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	04/26/2017		

POLICY

It is the policy of the clinic operations to provide availability of petty cash to front line staff to facilitate cash handling.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Sliding Fee Discount Program Policy

Policy #:	501-13	Effective Date:	2/26/2020
Business Unit:	Primary Care Clinics	Last Review Date:	12/31/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics and Finance
Board Approval Date:	2/26/2020		

PURPOSE

This program is designed to provide discounted care to those who have no means, or limited means, to pay for services (Uninsured or Underinsured). In addition to quality healthcare, patients are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full.

C. L. Brumback Primary Care Clinics (CLBPCC) will offer a Sliding Fee Discount Program uniformly to all patients. CLBPCC will base program eligibility on a person's ability to pay and family size. CLBPCC will not discriminate on the basis of age, gender, race, creed, disability or national origin. The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the Sliding Fee Schedule (SFS) to determine eligibility.

Individuals and families with annual incomes at or below 100 percent of the Federal Poverty Guidelines will be charged a nominal fee. No sliding fee discount will be available for individuals and families with annual incomes above 200 percent of the Federal Poverty Guidelines. CLBPCC SFS will apply for every service, including ancillary services, within CLBPCC's HRSA approved scope of project.

SCOPE

Primary Care Clinics; Finance; Revenue Cycle

POLICY

It is the policy of the CLBPCC to assess and evaluate a patient's ability to pay for all in-scope clinic services as well as services by paid referral and to make available discount services to those in need. All clinic patients will be assessed for income level unless they refuse. Discounts are determined based on household income and family size as defined in this policy. A sliding fee discount scale is used to calculate the applicable discount and is updated annually when the Federal Poverty Guidelines change. Discounts that are approved will be honored for six months, after which the patient must be reassessed. No patients will be denied health care services due to an individual's inability to pay for services of the health center.

It is the policy of CLBPCC to maintain a standard procedure to qualifying patients for sliding fee scale discounts for services provided. Sliding fee scale discounts are available to patients with all incomes at or below 200% of the Federal Poverty Guidelines. All services included within the scope of federal project, including all services provided directly and by referral will comply with HRSA sliding fee requirement. Patients with insurance are eligible to apply for the Sliding Fee Discount Program, and those who qualify will be charged the lesser of the patient liability or what they would be charged as an uninsured sliding fee patient unless prohibited by the applicable insurance contract. Patients that do not wish to apply for a sliding fee scale discount will be asked to attest to income and household size to be compliant with UDS reporting. Patients that refuse to be assessed may be billed full charges for their services.

It is the policy of the CLBPCC to post visible notices at all clinic sites, websites, and in printed material which state that no one will be denied access to services due to inability to pay, and that there is a Sliding Fee Discount Program available. This statement will be translated into the appropriate language/dialect and provided to patients upon request.

It is the policy of CLBPCC to ensure that when charging a nominal fee, the ability of the patient to pay is considered. Designated staff will periodically conduct a brief survey to those patients who were charged a nominal fee that allows patients to provide feedback about their charges.

The Board of Directors will review the Sliding Fee Discount Program Policy once every three years to ensure the policy in effect does not create a barrier to care, and if so, corrective action will be taken to eliminate those barriers. The evaluation will consider the perspective of all sliding fee patients through the use of tools such as patient surveys, focus groups and similar methods. The evaluation will also analyze patient and visit use data to ensure that the sliding fee patients of all classes are accessing services.

The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification**: CLBPCC will notify patients of the Sliding Fee Discount Program by:
    a. A “Welcome Packet” (brochure) will be available to all patients at the time of service.
    b. Notification of the Sliding Fee Discount Program will be offered to each patient upon registration.
    c. An explanation of our Sliding Fee Discount Program and our application form are available on CLBPCC’s website.
    d. CLBPCC places notification of the Sliding Fee Discount Program in the clinics’ waiting area.

2. All patients seeking healthcare services at CLBPCC are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**

3. **Request for discount**: Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk.

4. **Administration**: The Sliding Fee Scale Discount Program Policy and Procedure will be administered through the FQHC Clinic Coordinator. Information about the Sliding Fee Discount Program Policy and Procedure will be provided and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided services.

5. **Completion of Application**: The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize CLBPCC access in confirming income as disclosed on the application form. Providing false information on the Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

   If an application is unable to be completed or processed due to the need for additional information or a State of Emergency, the applicant has two (2) weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a patient does not provide the requested information within the two-week time period, their application will be re-dated to the date on which they supply the requested information. CLBPCC will work all patient accounts as detailed in its Billing and Collections Policy.

6. **Eligibility:** Discounts will be based on income and family size only. CLBPCC uses the Census Bureau definitions of each.
   a. **Family** is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
   b. **Income** includes earnings, unemployment compensation, workers' compensation, Social

Security, Supplemental Security income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.*

7. **Income verification:** Applicants must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. **Self-declaration of income** may only be used in special circumstances. Specific examples include participants who are living in unsheltered locations (such as streets, parks, temporary housing) coupled with an inability to pay. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to CLBPCC's Executive Director or his/her designee for review and final determination as to the sliding fee percentage. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

8. **Discounts:** Those with incomes at or below 100% of poverty will asked to pay a nominal fee. Partial discounts are provided for patients with incomes above 100% of the Federal Poverty Guidelines (FPG) and at or below 200% of the FPG. These discounts adjust based on gradations in income levels and include four discount pay classes. Those with incomes at or below 100% of poverty will not pay more than those with incomes above 100% of poverty. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines (FPG), http://aspe.hhs.gov/poverty. The primary care medical and dental sliding fee schedules are attached as a part of the policy.

9. **Nominal Fee:** Patients at or below 100% FPG will be assessed a nominal charge per visit. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment. The nominal charge is a flat fee, nominal from the patient's perspective, and is not based on actual cost of service.

10. **Waiving of Charges:** In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by

CLBPCC's Executive Director of Clinic Operations or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event). Patients who demonstrate financial hardship may request assistance by completing a Waiver of Fees Exemption Application. The Clinic Coordinator will review the application and forward to the Executive Director of Clinic Operations or designee for approval. Criteria reviewed includes, but not limited to:

1. Living in unsheltered locations (such as streets/parks/temporary home)
2. Eviction or facing eviction or foreclosure
3. Shut-off notices from a utility company
4. Experiencing domestic violence
5. Death of a close family member resulting in extreme financial constraints
6. Experiencing a fire, hurricane, flood or other natural or human-caused disaster that caused substantial damage to patient property
7. Filing bankruptcy
8. Medical expenses the patient could not pay that resulted in substantial debt
9. Unexpected increases in necessary expenses due to caring for an ill, disabled or aging family member
10. External medical crisis requiring frequent visits that make it challenging for the patient to pay
11. Other hardships that may prevent a patient from affording health care services subject to Executive Director of Clinic Operations or designee approval

11. **Applicant notification:** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the Sliding Fee Discount Program Discount, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with CLBPCC. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to the application date and any balances incurred within six months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the six months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program applications.

12. **Refusal to Pay:** CLBPCC does not refuse services to patients.

13. **Record keeping:** Information related to Sliding Fee Discount Program decision will be scanned by the

Front Desk staff and maintained electronically in the CLBPCC's Electronic Health Record in an effort to preserve the dignity of those receiving free or discounted care.

a. Applicants that have been approved for the Sliding Fee Discount Program will be annotated in CLBPCC's Electronic Practice Management system.

14. **Policy and procedure review**: Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the CEO and CFO and submitted to the Board for approval. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing the amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in the policy and procedures and for examining institutional practices, which may serve as barriers preventing eligible patients from having access to our community care provisions.

15. **Third Party Insurance.** Patients with third party insurance are subject to any limitations on further discounting amounts required by the insurer due to applicable Federal and state law, Medicare and Medicaid and / or terms and conditions of private payor contracts. Patients with insurance that are eligible for the SFS Program are charged no more than they would have owed under the SFS Program.

16. **Evaluation:** At a minimum, once every three years, the Sliding Fee Discount Program will be reviewed from the perspective of reducing patient financial barriers to care. CLBPCC shall include input from patients in various forms including, but not limited to, patient focus groups, patient surveys, and input from board members that are also patients of CLBPCC.

EXCEPTIONS

N/A

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RELATED DOCUMENTS	
Related Policy Document(s)	522-19
Related Forms	Waiver of Fees Exemption Application
Reference(s)	
Last Revision	05/23/2013,08/12/2013,05/24/2017,06/28/2017, 2/12/2019, 12/31/2019
Revision Information/Changes	
Next Review Date	

This policy is only intended to serve as a general guideline to assist staff in the delivery of patient care; it does not create standard(s) of care or standard(s) of practice. The final decision(s) as to patient management shall be based on the professional judgement of the health care providers(s) involved with the patient, taking into account the circumstances at that time. Any references are to sources, some parts of which were reviewed in connection with formulation of the policy/procedure. The references are not adopted in whole or in part by the hospital(s) or clinic(s) / provider(s).

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Health Care District Palm Beach County

Training Policy

Policy #:	510-16	Effective Date:	8/30/2016
Business Unit:	Primary Care Clinics	Last Review Date:	11/06/2019
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, HCD Rev Cycle
Board Approval Date:	08/30/2016		

POLICY

It is clinic operations policy to periodically train providers on the appropriate legal and ethical requirements pertaining to the billing process.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

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Health Care District Palm Beach County

Waiver of Fees Policy

Policy #:	522-19	Effective Date:	11/27/2019
Business Unit:	Primary Care Clinics	Last Review Date:	
Approval Group:	HCD Rev Cycle Policy	Document Owner(s):	Primary Care Clinics, Finance
Board Approval Date:	11/27/2019		

PURPOSE

C. L. Brumback Primary Care Clinics is committed to compliance with all applicable HRSA Compliance Manual Requirements. The purpose of this policy and the associated procedures is to provide safeguards to ensure C. L. Brumback Primary Care Clinics compliance with HRSA requirements.

SCOPE

Primary Care Clinics; Finance; Revenue Cycle

POLICY

C. L. Brumback Primary Care Clinics (CLBPCC) recognizes that patients who experience extenuating circumstances may qualify to receive an additional financial discount based on their Waiver of Fees Application. It is the policy of CLBPCC to ensure that services are provided to all patients without regard to the patient's ability to pay.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	
Related Forms	
Reference(s)	
Last Revision	
Revision Information/Changes	
Next Review Date	

This policy is only intended to serve as a general guideline to assist staff in the delivery of patient care; it does not create standard(s) of care or standard(s) of practice. The final decision(s) as to patient management shall be based on the professional judgement of the health care providers(s) involved with the patient, taking into account the circumstances at that time. Any references are to sources, some parts of which were reviewed in connection with formulation of the policy/procedure. The references are not adopted in whole or in part by the hospital(s) or clinic(s) / provider(s).

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DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
MARCH 12, 2021

1. Description: Change In Scope – Form 5B: C. L. Brumback Primary Care Clinics – North County PBG

2. Summary:

We respectfully request the authorization to add a new temporary site to Form 5B: C. L. Brumback Primary Care Clinics – North County PBG.

3. Substantive Analysis:

With demand for the COVID-19 vaccination rising, the C. L. Brumback Primary Care Clinics submitted a temporary change in scope to request 90-day provisionary approval for the North County PBG site to support outreach efforts.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Tony Colby
Interim VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board approve our request for a temporary Change in Scope to add a new site to Form 5B: C. L. Brumback Primary Care Clinics – North County PBG.

Approved for Legal sufficiency:

Christy Goddeau
Acting General Counsel

Dr. Hyla Fritsch
AVP & Executive Director of Clinics and
Pharmacy Services

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
MARCH 12, 2021

1. Description: Compliance with HRSA Monthly Meeting Requirement

2. Summary:

This agenda item is to function as a commitment to this Board's commitment to remain in compliance with this requirement.

3. Substantive Analysis:

Per Chapter 19 of the HRSA Compliance Manual, it is required that the Health Center Board hold *monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions*.

This Board is affirming their commitment to compliance with the HRSA monthly board meeting requirement.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Tony Colby
Interim Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board approve this agenda item as an attestation to its commitment to meeting monthly.

Approved for Legal sufficiency:

Christy Goddeau
Acting General Counsel

Dr. Hyla Fritsch
Executive Director of Clinic and Pharmacy Services

Chapter 19: Board Authority

Note: This chapter contains language that was revised based on the Bipartisan Budget Act of 2018. View the revisions. (PDF - 583 KB)

Authority

Section 330(k)(3)(H) of the PHS Act; 42 CFR 51c.303(i), 42 CFR 56.303(i), 42 CFR 51c.304(d), and 42 CFR 56.304(d); and 45 CFR 75.507(b)(2)

Requirements[1]

- The health center must establish a governing board[2] that has specific responsibility for oversight of the Health Center Program project.
- The health center governing board must develop bylaws which specify the responsibilities of the board.
- The health center governing board must assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations.
- The health center governing board must hold monthly meetings[3,4] and record in meeting minutes the board's attendance, key actions, and decisions.
- The health center governing board must approve the selection and termination/dismissal of the health center's Project Director/Chief Executive Officer (CEO).
- The health center governing board must have authority for establishing or adopting policies for the conduct of the Health Center Program project and for updating these policies when needed. Specifically, the health center governing board must have authority for:
    - Adopting policies for financial management practices and a system to ensure accountability for center resources (unless already established by the public agency as the Federal award or designation recipient), including periodically reviewing the

financial status of the health center and the results of the annual audit to ensure appropriate follow-up actions are taken;[5]

- Adopting policy for eligibility for services including criteria for partial payment schedules;[6]
- Establishing and maintaining general personnel policies for the health center (unless already established by the public agency as the Federal award or designation recipient), including those addressing selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices; and
- Adopting health care policies including quality-of-care audit procedures.

- The health center governing board must adopt health care policies including the:
  - Scope and availability of services to be provided within the Health Center Program project, including decisions to subaward or contract for a substantial portion of the services;[7,8]
  - Service site location(s);[9] and
  - Hours of operation of service sites.
- The health center governing board must review and approve the annual Health Center Program project budget.[10]
- The health center must develop its overall plan for the Health Center Program project under the direction of the governing board.
- The health center governing board must provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures.
- The health center governing board must assess the achievement of project objectives through evaluation of health center activities, including service utilization patterns, productivity [efficiency and effectiveness] of the center, and patient satisfaction.
- The health center governing board must ensure that a process is developed for hearing and resolving patient grievances.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program project, specifically:
   - The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;[11]
   - In cases where a health center collaborates with other entities in fulfilling the health center's HRSA-approved scope of project, such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
   - For public agencies with a co-applicant board;[12] the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant

board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.

b. The health center's articles of incorporation, bylaws, or other relevant documents outline the following required authorities and responsibilities of the governing board:
    - Holding monthly meetings;
    - Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
    - Approving the annual Health Center Program project budget and applications;
    - Approving health center services and the location and hours of operation of health center sites;
    - Evaluating the performance of the health center;
    - Establishing or adopting policy[13] related to the operations of the health center; and
    - Assuring the health center operates in compliance with applicable Federal, State, and local laws and regulations.

c. The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:
    - Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions;
    - Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project;
    - Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue;
    - Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services;
    - Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;
    - Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs; and
    - Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management,[14] and ensuring appropriate follow-up actions are taken regarding:
        - Achievement of project objectives;
        - Service utilization patterns;
        - Quality of care;
        - Efficiency and effectiveness of the center; and
        - Patient satisfaction, including addressing any patient grievances.

d. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies in the following areas: Sliding Fee Discount Program, Quality Improvement/Assurance, and Billing and Collections.[15]

e. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies. However, in cases where a public agency is the recipient of the Health Center Program Federal award or designation and has established a co-applicant structure, the public agency may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center board determines how to carry out required responsibilities, functions, and authorities in areas such as the following:
    - Whether to establish standing committees, including the number and type of such committees (for example, executive, finance, quality improvement, personnel, planning).
    - Whether to seek input or assistance from other organizations or subject matter experts (for example, joint committees for health centers that collaborate closely with other organizations, consultants, community leaders).
    - How often the Project Director/CEO performance is evaluated.
- The health center determines how to set quorum for board meetings consistent with state, territorial or other applicable law.
- The health center board determines the format of its long-range/strategic planning.
- For public agencies with co-applicant boards, the co-applicant board and the public agency determine how to collaborate in carrying out the Health Center Program project (for example, shared project assessment, public agency participation on board committees, joint preparation of grant applications).

Footnotes

1. The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board authority requirements discussed in this chapter. Section 330(k)(3)(H) of the PHS Act.
2. For public agencies that elect to have a co-applicant, these authorities and functions apply to the co-applicant board.
3. Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.
4. Boards of organizations receiving a Health Center Program award/designation only under section 330(g) may meet less than once a month during periods of the year, as specified in the bylaws, where monthly meetings are not practical due to health center patient migration out of the area. 42 CFR 56.304(d)(2).
5. See Chapter 15: Financial Management and Accounting Systems for more information on the related requirements.

6. See Chapter 9: Sliding Fee Discount Program for more information on the related requirements.
7. See Chapter 4: Required and Additional Health Services for more information on the requirements associated with providing services within the HRSA-approved scope of project.
8. See Chapter 12: Contracts and Subawards for more information on the requirements associated with such arrangements.
9. See Chapter 6: Accessible Locations and Hours of Operation for more information on the requirements associated with health center service sites and hours of operation.
10. See Chapter 17: Budget for more information on the requirements of the Health Center Program project budget.
11. This does not preclude an executive committee from taking actions on behalf of the board in emergencies, on which the full board will subsequently vote.
12. Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements. Public centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements.
13. The governing board of a health center is generally responsible for establishing and/or approving policies that govern health center operations, while the health center's staff is generally responsible for implementing and ensuring adherence to these policies (including through operating procedures).
14. For more information related to the production of reports associated with these topics, see Chapter 18: Program Monitoring and Data Reporting Systems, Chapter 15: Financial Management and Accounting Systems, and Chapter 10: Quality Improvement/Assurance.
15. Policies related to billing and collections that require board approval include those that address the waiving or reducing of amounts owed by patients due to inability to pay, and if applicable those that limit or deny services due to refusal to pay.

Previous Next

Date Last Reviewed: January 2018

Health Center Compliance Manual

Download the Health Center Compliance Manual (PDF - 1.8 MB - Last Updated August 2018)

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