VIRGINIA DEPARTMENT OF HEALTH

Eligibility and Charging Structure GUIDANCE DOCUMENT

March 26, 2019

Approved:

_____ _____

Commissioner of Health Date

General Comments and Overview

The regulations in the Virginia Administrative Code governing eligibility standards and charges for medical care services to individuals, as approved by the Board of Health, are necessarily somewhat general in nature and cannot be written to cover every circumstance. For this reason, the Commissioner of Health is granted the authority to interpret the regulations so that they are applied consistently to myriad specific circumstances, and to incorporate experience gained in applying the regulations to meet the challenges of delivering health care in an ever-changing environment. This Guidance Document provides those interpretations.

Each section of the regulations, e.g., 12VAC5-200-10, is listed in the order in which it appears in the regulations. All the sections are listed; however, the amount of material after each section varies considerably. If there is no information, the section is believed to be self-explanatory. Except for the section titles, the Guidance Document generally does not repeat textual material from the regulations.

The Guidance Document is reviewed whenever the regulations are reviewed, or as needed. Changes are approved by the Commissioner of Health and are effective upon approval.

This document was originally approved on March 28, 2004 and was last modified on March 26, 2019.

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CHAPTER 200
Regulations Governing Eligibility Standards and Charges for Medical Care Services to Individuals

Part I
Definitions

12VAC5-200-10. Definitions

College Student

College students are normally considered full-pay patients whose charges are not discounted. A district director may choose to discount the charges to all college students. If a district discounts charges for college students, and a college student wishes to receive discounted charges, he or she must undergo the same eligibility determination as any other patient and be identified as part of an appropriate family or economic unit. College students who currently receive any support from their family are considered part of that family, and the family's income must be included when determining the student's charges. Such support may take the form of money payments to the student, student expenses paid directly by the parent(s), or in-kind support. If the student resides with his or her parent(s) during breaks from class or during vacations, the student is considered to be receiving in-kind family support, and the family's income should be included in determining the student's charges.

If a student is married, he or she and his or her spouse are generally considered the family unit, and the spouse's income must be included in determining the student's charges.

If an unmarried student can demonstrate that he or she receives no support of any type from his or her family, either financial or in-kind, the student may be considered a family or economic unit of one.

Health districts may bill any health insurance plan that provides coverage for the student. College students shall receive non-chargeable services (as defined in the regulations) at no cost. ***College students who are minors will be treated in accordance with the procedures applicable to minors***.

Do Not Contact (DNC)

A DNC patient is any person receiving Family Planning, maternity, sexually transmitted infection (STI), or HIV services and who requests that no bills or notices for these services be sent to his or her home.[1] Prior to services being rendered, health department staff shall provide the DNC patient with an explanation of the charges, applicable discounts, and expected payment.

[1] In accordance with Title X, this is intended to protect the confidentiality of patients receiving sensitive services.

Maternity patients who request DNC status are generally DNC patients only for a limited time, i.e., until it becomes obvious that they are pregnant. A health district must determine when to end a maternity patient's DNC status on a case-by-case basis, taking into account relevant factors. All DNC patients should have their DNC status reestablished at each visit.

Health districts should arrange for an alternative method of communication whereby a DNC patient can be contacted without violating the patient's confidentiality. This allows health districts to inform patients of needed follow-up services, e.g., following an abnormal Pap smear, and for notifying patients of their unpaid bills. DNC patients' unpaid charges for these services shall not be referred to a collection agency for debt set-off, and patients shall not be denied service due to unpaid charges.

Family, Family Unit, or Economic Unit

Family units or economic units (used interchangeably for eligibility purposes) may consist of:

A. Spouses and their minor dependents.

B. A single individual and his/her minor dependents.

C. An individual with no minor dependents.

D. Individuals who pool or commingle their income.

1. All related or non-related persons who share income as an economic unit shall be counted as part of a family unit. "Shared income" is income that is pooled or commingled to support the economic unit. For eligibility purposes, the total income from all members of the economic unit should be used to determine the applicant's income level. "Shared expenses" are not the same as "shared income" and do not define an economic unit. For example,

   - Students or other individuals who share the rent for an apartment but who do not share or commingle their incomes would not be considered a family or economic unit.

   - An adult patient lives with her parents. The patient is employed and pays her own expenses. She pays rent to her parents. The patient would be considered a family unit of one and only her income would be used for eligibility because payment of rent to parents does not constitute pooling of income.

   - An unmarried patient lives with a companion. Both are employed. They are both signators on their apartment lease and pay living expenses for

food, utilities, etc. out of both incomes. The patient and the companion would be considered an economic unit of two, and both incomes would be used for eligibility determination.

2. A woman who is pregnant should be counted as a multiple beneficiary, i.e., the mother and the baby (or babies) are counted together, when the pregnancy has been verified by a physician or a nurse practitioner working under the supervision of a physician. Alternatively, the pregnancy may be verified by a nurse based on a compatible clinical history and a positive pregnancy test. Verification by a nurse becomes effective on the date the nurse makes the determination, but the pregnancy must also be verified by a physician, or a nurse practitioner working under the supervision of a physician, at the next prenatal visit.

3. Spouses who are separated and are not living together shall be considered separate units. Spouses who are legally separated but living together and sharing their income are considered a single economic unit despite their separated status. *This determination should be made by questioning the client and documenting the client's answers in the client's record.*

4. Proof of dependency from the Internal Revenue Service is not considered a basis for the determination of a family or economic unit. For instance, the following are examples of minors who are considered separate family or economic units:

    A. A minor placed in a foster care home and who is the legal responsibility of a welfare agency.

    B. A minor living with a legal guardian who does not have financial responsibility for the minor.

5. A Medicaid recipient who is a minor receiving Special Supplemental Income (SSI) payments shall be considered a separate family unit. Furthermore, he or she is not part of the larger family unit when calculating the larger family unit's income.

6. A Medicaid recipient who is a minor not receiving SSI shall be considered part of a family unit as described above.

7. Individuals requesting DNC status shall be treated as one economic unit and shall require an eligibility determination.

8. In cases of joint custody of a minor, both parents must designate a head of family. The family unit will be that of the designated head and his/her family unit plus the child in joint custody. If the head of the family unit is not

designated, the parent present with the minor child will be considered the head of the family.

9. The family unit for a parent who is paying child support excludes the minors for whom the child support payments are intended. The family unit which receives child support payments shall include the minors for whom the child support payments are intended.

Gross Income

Proof of Income. In the majority of cases, income can be verified by determining the family's monetary wages and salaries before any deductions or withholdings (i.e., gross income). Wage and salary verification must be determined for all adults in the family (earned incomes of minor children are excluded). If there is any question about the authenticity of the pay stub (e.g., there is no name or social security number), staff may require a statement from the employer on company letterhead. Staff should be sure to determine whether multiple family members are working.

The following documentation can be used as proof of income:

1. Pay stub with year-to-date total. If the calendar year-to-date total is on the stub, the applicant was employed by the same employer since January 1st, and the year-to-date income covers three or more months of continuous employment, then only one pay stub is needed. In cases where the paystub is presented at registration by the patient using a mobile device with no ability to print, the information must be viewed and confirmed by the eligibility worker. In addition, the eligibility worker must document the pertinent information from the electronic document produced, write a statement to explain how the information was obtained/confirmed, sign and date the document, and have it co-signed by the patient. The patient should be asked to bring a printed copy of the income document, if available, at the next visit.

2. If year-to-date totals are not available, then check stubs for the past three consecutive pay periods are recommended.

3. For people who have worked on their current job for less than three months, use current check stubs to determine a regular amount of pay (hourly, weekly, monthly, etc.) and calculate income as if the person were working the entire year.

4. Persons on strike shall be treated as persons who have changed jobs.

5. Persons who are employed but off the payroll for sickness or some other reason should have their family income figured based on the income at the

time of application. When they return to work, a new eligibility must be completed.

6. In some cases, it may be inappropriate to use check stubs as verification (seasonal workers, for example). In those cases, an IRS Form W-2 from the previous year should be requested.

7. When making the initial eligibility determination, if the interviewer notes a large amount of overtime as part of the gross income, the applicant should be asked if the overtime is a regular occurrence. If it is regular, the overtime is counted as part of gross earnings. If it is not regular, the overtime is not counted as part of the gross earnings. All pay stubs must note the pay period for which the stated income was earned.

8. If no wage or salary statements are available, then the following verifications are acceptable:

    A. The most recent annual tax return should be requested. The total income is shown on line 22 of the IRS Form 1040 (line15 on the 1040A form, and line 4 on the 1040 EZ form). If the applicant is self-employed, income is figured as above along with any depreciation shown on line 13 of Schedule C. If income includes or is entirely farm-based, it must include any depreciation taken on Schedule F (line 14).

    B. If no tax return is available, one of the following will be considered as adequate proof of income:

        (1) A statement from the employer (see Appendix C). This is required to be on company letterhead, dated, signed by a company official, and have sufficient information to allow calculation of current gross pay. Although a letterhead statement is preferred in all cases, the district may accept a statement written on plain paper. If neither of these is available, the district director may accept a self-declaration of income. For exceptional cases, oral verification from the employer also may be used as proof of income.

        (2) Some people who are self-employed may only have ledgers that they keep with their business' revenues and expenses. When these ledgers are brought in as proof-of-income, one of two approaches may be used:

            (a) If possible, determine what they paid themselves and their family members.

(b) If (a) is not possible, determine their revenues and subtract all expenses except depreciation. This remaining total will constitute their gross income.

(3) In certain cases, a self-declaration of income is acceptable. Examples are those who are homeless (and/or live in a shelter) and day workers. Individuals who earn tips can report them in this manner. The applicant should be asked to write out a statement such as "My estimated yearly income is _____." The statement must be signed and dated by the applicant.

(a) Migrant and seasonal workers may also self-declare their income.

(4) A signed letter from the Department of Social Services including the income used by Social Services to determine eligibility.

9. Social Security and Railroad Retirement. Any one of the sources listed below may be used as verification:

A. Documents stating the amount of entitlement.

B. Official award letter or notice.

C. Benefit payment check or proof of direct deposit account. Deductions for Medicare Part B are to be added to this amount to compute total monthly income.

D. If none of the above sources are available, other sources, such as an adult child, may be contacted, but only with the written consent of the applicant.

10. Persons Receiving Unemployment Benefits. The only allowable verification is a statement from the Virginia Employment Commission stating the amount of benefits and the weeks remaining. The person receiving unemployment benefits should be treated as a person who has changed jobs. (Refer to #3 above.)

11. Worker's Compensation/Veteran's Benefits. (Note: A person receiving these benefits could also be currently employed.) Any one of the sources listed below may be used for verification:

A. Documents stating the amount of the payment.

B. Benefit payment check or proof of direct deposit amount.

12. Applicant Claims to Have No Income. All applicants claiming no income should be questioned about how they are supporting themselves. The interviewer should also make certain that they are identifying the correct family unit.

    A. If the applicant states that he/she has no income, the following documentation may be used:

        (1) Statement from Virginia Employment Commission denying unemployment compensation,

        (2) Termination notice from previous employer, or

        (3) Layoff notice from previous employer.

    B. Applicants (other than Family Planning patients and DNC applicants seeking confidential Family Planning, STI, HIV, or maternity services) who have no income and none of the documents listed in 12-A may self-declare that they have no income by signing a simple statement to that effect (see sample statement, Appendix B). The statement should list possible sources of income, and the declaratory statement should indicate that the applicant has no income from any of those sources.

        A self-declaration of income initially establishes the applicant as a full-pay patient. For patients seeking Family Planning and/or STI services, the self-declaration requires no further documentation. For all other services, the applicant has 30 calendar days to obtain a “proof of no income” letter that identifies the source of the applicant's food and shelter. The letter must be from an appropriate institution (e.g., a church or shelter) and must be on the institution's letterhead stationery (see sample statement, Appendix C). Upon presentation of a “proof of no income” letter, the applicant will be reclassified as an “Income Level A” patient.

        If the applicant is dependent on a relative, friend, or some other non-institutional source of support, the individual providing the source of support must provide a "proof of no income" letter (see sample statement, Appendix D). The individual must include in the letter a statement of his relationship to the applicant and a certification as to the truthfulness of the letter. The applicant may bring in the relative or friend, along with the letter, and have the relative or friend certify its authenticity. Each district may determine for itself the authentication it will consider acceptable. Alternatively, the relative or friend may send a notarized letter. As a third alternative, the district director may accept a "proof of no income" letter from the applicant.

If the applicant does not provide a “proof of no income" letter or other documentation within 30 days, the applicant remains classified as “full pay,” and the district shall attempt to collect full payment from the applicant. A “proof of no income" letter must be renewed annually.

13. Alimony/Child Support. This can be verified by the applicant providing any legal document (e.g., divorce papers, letters of support, judgments, custody papers, copies of checks) that state the amount and frequency of payments. A written declaration of child support is also acceptable. A copy of the ex-spouse's tax return showing alimony payments would also be acceptable.

14. Military Pay. The most recent copy of the military member’s Leave and Earnings Statement (LES) form must be used to determine income. Income includes monthly base pay, hazardous duty pay, “bonus pay(s),” and any other special pay(s). Income does not include allowances for subsistence, quarters, or quarters in high-cost housing areas.

15. Training Stipends. These are funds paid to a person while in training, including Job Corps or payments of part or all of a salary while in school. Verification can be made by check stub or by a letter of award that the student receives.

16. Child in Foster Care. Children in foster care are considered separate families. Any payment from the Department of Social Services for their care should be considered part of the child's income and not part of the foster parents' income.

17. Family with Income Only from Checking/Savings Accounts. Sometimes, an applicant may claim no income but have a sizable amount of money (i.e., a combined amount of more than $10,000[2]) in a checking and/or savings account. The district can verify this income by requiring the applicant to bring a current account statement, passbook, or other document displaying the amount of money in the account. In such cases, the interviewer needs to determine if the amount is earned income. "Earned income" is income that the family was able to save when a family member was employed.

    A. If the amount is from earned income, only the interest from those accounts should be counted as income.

    B. If the amount is not earned income (examples: money brought into the country by legal aliens, past judgment awards), then the entire amount in the accounts is to be considered as income. It would also be permissible to use the amount that was withdrawn from the accounts in one year's time, but the applicant must have bank records to prove the difference.

[2] This threshold is based upon the IRS Bank Secrecy Act and requirement to report payments of more than $10,000.

18. Other Types of Benefits.

    A. Private Pensions/Military Retirement Pay. The same types of verifications are acceptable as for a recipient of Social Security. As for most categories, tax records are acceptable.

    B. Regular Insurance or Annuity Payment. See 9A above.

    C. Dividends and Interest. Acceptable types of verification are bank statements (quarterly or semi-annual statements provide a better picture of what the annualized amount would be), the past year's 1099, or a copy of the applicant's past year IRS Form 1040. Dividends are on line 9; interest is on lines 8a and 8b. For the self-employed and in other cases where the total income is used (line 22 of the Form 1040), it is not necessary to add in dividends and interest and other sources of income.

    D. Net Rental Income. Review the relevant tax information. The details are included in Schedule E and will be included on line 17 of IRS Form 1040.

    E. Net Royalties. Review the relevant tax information. The details are included in Schedule E and will be included on line 17 of IRS Form 1040.

    F. Periodic Receipts from Estates or Trusts. Several possible sources of verification are acceptable. These include copies of legal documents, tax records, IRS Form 1099, and bank records.

    G. Lump Sum Settlements. These include inheritances, one-time insurance payments, and injury compensation awards. Verification can be made by checking the award letter or copying the check. In some cases, it may be necessary to check with the court.

    H. Net Gambling Winnings. These are included on line 21 (“Other Income”) of IRS Form 1040 and are, therefore, part of the line 22 total.

    I. Lottery Winnings. Although the recipient should be asked about any income derived from lottery winnings, verification is not required unless the applicant is known to have won a large prize, defined as $1,000 or more. Lottery winnings are included on line 21, “Other Income,” of IRS Form 1040.

19. Gross income does not include:

A. Food stamps.

B. WIC checks.

C. Fuel-assistance payments.

D. Housing assistance.

E. Money borrowed.

F. Tax refunds.

G. Gifts.

H. Withdrawal of earned income from bank accounts. Interest is to be included as income.

I. Earnings of minor children.

J. Money received from the sale of property.

K. General relief from the Department of Social Services.

L. College or university scholarships, grants, fellowships, and assistantships when provided to pay for, or in the form of, tuition, fees, other direct educational expenses, housing, or meals.

Medically Indigent

Synonymous with Income Level A.

Minor

A minor is an unmarried person less than 18 years of age whose parents are responsible for his or her care. A minor will be considered a separate family unit when married or not living with any relative or deemed an adult.

A minor may be deemed an adult for the purposes of consenting to Family Planning, maternity services, testing or treatment for sexually transmitted infection (STI), HIV services, or any reportable infectious or contagious disease.

A minor will be treated as an economic unit of one when he or she seeks ***confidential*** services for a sexually transmitted infection, HIV infection, Family Planning, or maternity services (including the diagnosis of a possible pregnancy).

(Additionally, these four services may be provided confidentially to a minor without consulting or informing his or her parents.) Minors seeking these ***confidential*** services should automatically be treated as Income Level A patients unless the district has reason to believe that the minor, as an ***economic unit of one***, has income that exceeds Income Level A. An eligibility determination must still be completed for these minors.

Minors seeking Family Planning services pose special issues of confidentiality even when they do not ask for confidentiality or DNC status because minors may be reluctant to admit they are there without their parents' knowledge. For example,

- A minor seeking Family Planning services arrives without a parent or guardian:
    - If the minor brings her parents' pay stubs or other proof of family income, she and the family are treated as an economic unit and her parent's pay stubs or other documentation are used to make the eligibility determination.
    - If the minor does not bring proof of family income, the interviewer checks to determine if the parent or guardian is already on file in connection with other services received from the health department. If so, the same eligibility determination will be used for the minor. If the eligibility is at Level B through G, the minor will be informed that there will be a charge for services and that the guarantor will be billed.
    - If no prior eligibility determination is found for the parent or guardian, the minor is asked to complete a self-declaration of family income as described below in section 12VAC5-200-80, Application Process, Special Eligibility Procedures, Family Planning.

<u>Non-Chargeable Services</u>

Non-chargeable services are defined in section 12VAC5-200-150 of these guidelines.

Part II
General Information

Part III
Application and Charges

12VAC5-200-80. Application Process

The application process begins when the Community Health Services (CHS) CHS-1A form, Patient Application and Consent for Health Care, is completed, an eligibility interview is conducted, proof of income and identification is requested from the patient, and the patient is appropriately classified according to income level and family size so that eligibility for discounts for medical care services can be determined. Identification and source documents to support registration and eligibility determination, e.g., Medicaid or insurance cards, pay stubs, other proof of income, or self-declaration documents, shall be copied and filed in the appropriate patient record. Patients shall not be refused service for failure to provide identification or other documents.

Citizenship Status

Citizenship and immigration status shall not be included as factors in VDH eligibility requirements.

- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 as amended (PRWORA), was passed as a reform of the federal welfare system. Title IV of the Act defines public assistance to aliens and specifies that only “qualified aliens” (as defined in the Act) are eligible, with certain exceptions, for “federal public benefits” or “state or local public benefits.”

- VDH programs are not “federal or state public benefits” as defined in the basic statute and in implementation regulations published by the Department of Justice, the Department of Health and Human Services, and the Department of Agriculture. In accordance with the U.S. Attorney General’s guidance, and to avoid the risk of national origin discrimination, inquiry as to citizenship or immigration status shall not be made of applicants for VDH services.

Social Security Number

The Privacy Act of 1974, § 7(a), prohibits states from requiring individuals to disclose their social security number (SSN), unless it is required by federal statute or the state has a system of records in place that was operating before January 1, 1975 and disclosure of the SSN was required under a statute or regulation adopted prior to this date. In accordance with this statute, VDH does not have authority to require SSNs from clients, nor may VDH deny or restrict clinical services or apply special payment requirements because of a refusal by a client to supply an SSN.

Members of a patient's family are also not *required* to supply their SSNs as part of the eligibility process. One or more family members could refuse to supply the SSN, while others in the family might voluntarily supply their SSNs. If the patient is a child, only the child's SSN is in question and the parent may or may not supply it. The parent is not *required* to supply his or her own SSN.

All applicants should be informed (1) that providing an SSN is voluntary and that if they choose not to supply an SSN, they will not be denied service or treated differently in any way; and (2) that VDH will use an SSN only to verify identification; maintain patient records; verify income by cross-matching with the Virginia Employment Commission; assist with collection efforts should that become necessary; and process refunds of payments, if any, for the patient.

Residency Requirements

Residency restrictions may be established by the district director to the extent permitted in 12VAC5-200-190, Limitations, below.

General Eligibility Procedures

This section describes the general eligibility determination process applicable to most medical services. The next section describes special procedures for Family Planning, WIC, Child Care Connection (CCC), and Child Development Clinic (CDC) services.

- If a valid proof-of-income is not presented at the time the CHS-1A, Patient Application and Consent for Health Care, is completed, the applicant will receive no discount for services received unless he or she provides proof of income within 30 days or at the next visit, whichever is sooner. If a valid proof-of-income is provided within 30 days, charges will be discounted back to the date of completion of the original CHS-1A. If the applicant does not provide proof-of-income with 30 days, no discounts will be given for prior services. If an applicant provides the information after 30 days and is determined to be medically indigent, the previous charges may be discounted at the district director's discretion.

- If a client is part of an economic unit that refuses to supply the client with necessary proof of income information for an eligibility determination to be completed, the district director may approve use of a self-declaration of household income without further requirement for proof of income from that economic unit. VDH staff should be sensitive to such situations and should thoroughly question the applicant to ascertain the facts. If the explanation seems reasonable in the judgment of the interviewer, the matter should be discussed with the interviewer's supervisor. If the supervisor concurs, the case shall be referred to the district director or any other manager responsible

for financial operations of the district (e.g., business manager, eligibility manager), who may approve use of a self-declaration of household income (see Appendix E), which shall be used as the basis for the eligibility determination without further requirement for proof of income from other family members. See Appendix G for district director summary.

If an applicant receives a Medicaid card after the eligibility date, Medicaid shall be billed for all possible charges. Any credits to the account shall be refunded to the applicant. If the applicant is a minor whose parent, or other adult who is fiscally responsible for the minor's charges, paid the minor's charges, any refund should be issued to the parent or other adult using the parent's social security or alien registration number, if available.

A new eligibility must be completed every 12 months, or other frequency as required by a specific program. Eligibility determinations should also be completed when 1) The health district has reason to believe the patient's eligibility status or family composition has changed, 2) The patient has an overdue account and denial of service is contemplated, or 3) A patient requests a waiver. A new CHS-1A must be signed every 12 months, or any time an update is made to an eligibility determination, e.g., change of income or family size.

To the extent possible, the health district shall attempt to verify income information by accessing the databases of the Virginia Employment Commission (VEC) to determine if there is a record of income earned by the patient and/or any of the named household members. If such income information is identified, the data will be discussed with the applicant to determine if it should be used as the basis for the eligibility determination, or if changes in the applicant's financial situation have occurred that make the VEC data obsolete or incorrect. If no reasonable explanation is provided for an exception, the VEC data shall be used.

If a VDH clinic seeks to maintain efficient patient flow by temporarily postponing the eligibility step in order to get the patient to an available clinician, it is an acceptable practice to do so. However, before moving to the clinician, the patient must be informed of the fee; that the eligibility step being temporarily skipped will be completed that same day; and that eligibility will determine whether they must pay no fee, part of the fee, or all of the fee under the sliding scale. If staff is not available to explain this, the district must have a plain-language document (in at least two languages) that the clinic can provide to waiting patients in order to explain the process. The patient must be given the option of waiting until an eligibility determination can be made before moving to the clinician. If the patient elects to wait for the eligibility determination, the next patient in line can be offered the explanation and option, and so on. Even if the patient is not advised of the option, the eligibility step must not be skipped. In no circumstance will a patient be provided service without completion of a required eligibility determination.

Special Eligibility Procedures

Sexually Transmitted Infections (STI): Proof of Income and Self-Declaration for STI Patients. The normal proof-of-income documents (e.g., pay stubs, etc.) shall be requested from all STI patients. The definitions and guidance (in Part II) relating to proof of income apply to STI patients. However, to facilitate clinic registration and streamline processes with Family Planning, patients who present at an STI clinic without proof of income may self-declare their family income (see sample in Appendix E). The eligibility determination regarding income level shall be based on the income listed in that self-declaration. STI patients are ***not*** to be classified as full-fee patients pending receipt of proof-of-income documents. A self-declaration done in an STI clinic will also be applicable in a Family Planning clinic.

If the STI patient seeks medical services other than those in the STI or Family Planning clinic, another eligibility determination must be made, and proof of income will be ***required*** as usual for those clinical services.

Family Planning. (Note: The procedures described in this section are applicable ***only*** to patients who are Family Planning clinic patients. They are not applicable to WIC or other clinics' patients, who may also seek Family Planning services during their visit.)

VDH Family Planning services are partially funded by federal Title X grants. Title X regulations require that every Family Planning patient must receive an eligibility determination, except in the case of patients who have qualified for Medicaid. Title X also specifies that no Family Planning patient may be denied service because of inability to pay. Through its eligibility determination process and application of the sliding scale, VDH is in full compliance with this requirement. The eligibility process identifies those patients who are unable to pay and assigns them to Income Level A. The fees for all other Family Planning patients, i.e., those who have an ability to pay, are computed on the sliding scale based on their income and family characteristics.

The normal proof-of-income documents shall be requested from Family Planning patients. The definitions and guidance in Part II relating to proof of income apply to Family Planning patients. For these patients, however, the following special procedures also apply.

Self-Declaration and Proof of Income for Family Planning Patients. According to guidance received from the federal Office of Family Planning,

> "Title X projects may ***request*** proof of income, but they may not require it. Thus, if a client has no proof of income, but provides a self-declaration of income, the Title X project should accept the self-declaration and charge the client based upon what he or she has declared. Title X projects may not

> assess the client at 100% of the charge because they do not have proof of income, as this may present a barrier to the receipt of services."

In accordance with this guidance, if patients who present at a Family Planning clinic do not have proof-of-income documents (e.g., pay stubs, etc.) with them, they may self-declare their family income (see sample in Appendix E), and the eligibility determination pertaining to income level shall be based on the income listed in that self-declaration. They will ***not*** be classified as full-fee patients pending receipt of proof of income documents.

If the Family Planning patient seeks medical services other than those in the Family Planning clinic, another eligibility determination must be made, and proof of income will be ***required*** as usual for those clinical services. Furthermore,

- If the patient provides the proof of income documents required for the other medical services, the resulting eligibility determination will supersede the original Family Planning determination based on the self-declaration.
- If the patient does not provide proof of income for eligibility determination, the general rules apply and the patient will be classified as full-pay for those medical services until the necessary documentation is supplied or a waiver is approved as described in the general rules.
- If the patient later returns for follow-up Family Planning services or supplies while the full-pay status is in effect for the other medical services, the original Family Planning eligibility determination based on the Family Planning self-declaration continues in force for the Family Planning services or supplies, and the full-pay status continues for the other medical services.

The Family Planning self-declaration will remain in effect until the next annual verification period or the patient informs VDH of any changes prior to that time. A self-declaration completed in a Family Planning clinic will also apply in an STI clinic.

Minors seeking Family Planning services pose additional issues of confidentiality, even when they do not request DNC status. See the discussion of such cases above in section 12VAC5-200-10, Definitions, Minor.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The WIC program requires receipt of proof-of-income before certification and delivery of services.

Care Connection for Children (CCC). The CCC program requires receipt of proof-of-income before certification and delivery of services. As applicable, CCC also

requires proof of the applicant having applied to Medicaid, Supplemental Security Income (SSI), or any other state-sponsored medical insurance program.

Child Development Clinic (CDC). If applicable, CDC applicants must also supply proof that they have applied to Medicaid, SSI, or any other state-sponsored medical insurance program.

12VAC5-200-90. Charges for Services

Overview

Unless otherwise specified, the provisions of this and the following sections pertaining to charges for services, billing, collections, and denial of service are applicable equally to all patients served at all VDH medical clinics, *including Family Planning clinics funded in whole or in part by federal Title X grants.*

Services provided by health districts can be grouped into two broad categories, "clinical care" provided by health district personnel, and "goods" such as biologicals, pharmaceuticals, and diagnostic tests ordered by district personnel.

- Clinical care services are charged on a "sliding scale" based upon a patient's income and thus represent a discount from the "standard" charge, which is usually the Medicaid charge. Charges for Income Level A patients are discounted 100%, i.e., they pay nothing. Income Levels B-F patients pay a discounted charge, as detailed in 12VAC5-200-10, 12VAC5-200-20, and 12VAC5-200-110, and elsewhere in this Guidance Document. Income G, or "full-pay" patients, pay the standard charge.

- "Goods" are charged on a "flat rate charge" basis, representing the cost to the local health district of the goods provided to/ordered for the patient, plus, in some cases, an appropriate handling or administration charge. In general, there is no discounting of flat rate charges based upon income, and even Income Level A patients pay 100% of the flat rate charge.

(Services that must be provided at no charge to all patients are excluded from sliding scale and flat rate charges.)

Establishment and Promulgation of Charges

The commissioner may designate an individual to maintain and update the tables listing the medical care services charges and codes, and to disseminate updated information to the districts and other relevant individuals or positions. The commissioner or designee has the authority to determine new charges when there are no appropriate Medicaid or Medicare charges, and to establish convenience charges (e.g., charges rounded to the nearest dollar).

Districts may submit requests for new charges (and codes) or changes in existing charges (and codes) to the commissioner or his designee. Districts may not implement new charges (and codes) or change existing charges (and codes) without the prior permission of the commissioner or his designee.

Whenever possible, charges for services will use the most appropriate current Medicaid charges, with matching Medicaid codes. If there is no Medicaid charge or code for a particular service, the most appropriate current Medicare charge and code will be used. If both Medicaid and Medicare charges and codes exist for the same service, the Medicaid charge/code will be used.

If neither a Medicaid nor a Medicare charge or code exists for a particular service, the commissioner or his designee will determine an appropriate charge and code. Estimated or actual costs associated with providing the service, including an administration or handling charge when appropriate, will be determined by one or more districts and submitted to the commissioner or his designee. The submission will include sufficient documentation to support the reported costs. The commissioner or his designee will review this information and determine a standard charge and code that will apply throughout the state, except that the charge for services in Northern Virginia (as defined in 12VAC5-200-10) may be 10% higher than the charge in the rest of the state.

When medical care services are provided to persons with private health insurance that covers the service being provided, the charge will be the amount equal to the allowable charge of the insurance company for the service being provided. If the insurance company denies the claim for medical care services provided, the patient portion of the bill will not be greater than if the person did not have private health insurance (§ 32.1-11).

Charges may include additional charges to cover mileage or other ancillary costs associated with providing a service. For example (and for illustrative purposes only), if the service is provided away from a health district facility, there might be no additional charge for services provided within five miles of the facility; however, there may be a $5.00 additional charge for services provided more than five miles but less than 15 miles from a facility, and so forth. The commissioner or his designee must approve any such additional charges.

Any Medicaid or Medicare charges that are higher in Northern Virginia will remain in effect. The commissioner or his designee may add additional medical care services to the list of those for which a higher charge is allowed in Northern Virginia.

The costs of any products (goods) or services which are obtained through a central purchasing contract will be charged to patients at the same rate throughout the state, i.e., higher charges are not permitted in Northern Virginia for these items unless the purchasing contract specifically indicates health

districts in Northern Virginia will pay a higher price. Any administration, handling, or other service charges added to these items will be the same throughout the state.

An underlying assumption of this section is that the majority of services and charges provided by health districts are available through state contracts or other standard arrangements, and therefore the costs are the same to all health districts. Where services and products are available only from local vendors, or for practical reasons when they must be obtained from local vendors, health districts may request a charge be established that is appropriate to the district's circumstances. In these cases, the district will submit appropriate justification for using a local vendor with their request to the commissioner or his designee.

12VAC5-200-100. Flat Rate Charges

1. Unless otherwise approved by the commissioner or designee, all charges shall be on a sliding-scale basis, and there shall be no charge for Income Level A patients.

    a. In general, all clinical services and procedures provided by health district personnel (i.e., physicians, dentists, nurses, nurse's aides, pharmacists, and other health care professionals) shall be charged on a sliding-scale basis. Conceptually, these services may be thought of as "hands on" services by a health care provider (e.g., taking a medical history, performing an examination or procedure, or otherwise assessing a patient). Included in the basic sliding-scale charge for any given service are the costs of any consumable supplies associated with the service such as gloves, examination gowns, necessary examination equipment, and surgical instruments. Patients may not be charged extra for these items.

        i. Family Planning services that are supported in whole or part by federal Title X or Title V funds *must* be charged on a sliding-scale basis. The sliding scale must also must be applied to Pap smears, all contraceptive methods, and other tests obtained as part of the patient's evaluation. Family Planning patients at Income Level A cannot be charged for any services, including Pap smears or other tests, or contraceptive products. Please note that if an outside lab is going to bill patients' insurance, then the sliding scale will not be applied to these charges.
        ii. Family Planning patients who receive Pap smears in clinical settings other than Family Planning (e.g., a sexually transmitted infection clinic) may be charged for their Pap smears in accordance with procedures in effect at that other clinic.

b. In general, if approved by the commissioner or his designee, flat rate charges apply to goods purchased by health districts and provided to patients. They also apply to certain services arranged by the health district (i.e., ordered by its health care providers) and provided by others, or in some cases by the health district. Flat rate charges generally apply to pharmaceutical and biological products (except those services described in 12VAC5-200-150, “Services Provided at No Charge to the Patient”), laboratory tests, and other tests and diagnostic procedures.

2. The commissioner or his designee must approve flat rate charges prior to implementation. This includes both approval to charge a flat rate charge and the specific charge itself. The commissioner or his designee shall maintain and promulgate to the districts lists of sliding scale and approved flat rate charged services along with their appropriate charges.

3. If the cost of a flat rate charged item, plus any handling or administration charge, is less than the charge approved by Medicaid, Medicare, or the commissioner or designee, the district may not increase the charge to match that allowed by Medicaid, Medicare, or the commissioner or his designee. The district may request the commissioner or his designee be allowed to increase the charge.

4. District directors have the authority to apply sliding-scale discounts to goods or services for which flat rate charges have been approved (see Appendix G for details).

Pre-Approved Flat Rate Charges

The commissioner has approved the use of flat rate charges for the following categories of goods and services. The complete list of goods and services for which flat rate charges have been approved may be found in the database maintained by the commissioner or his designee.

1. Travel Medicine Services. Health districts may charge flat rate charges for goods and services, including vaccines and their administration (except those described in 12VAC5-200-150, “Services Provided at No charge to the Patient”), which they provide to a patient who requests medical advice for travel outside the United States. Patients may be charged for the evaluation and recommendations, immunizations, and other goods or services provided to them.

2. Mass Clinics. Health districts may charge a flat rate charge for services at special mass clinics (except those described in 12VAC5-200-150, “Services Provided at No Charge to the Patient”). The intent is to allow health districts to provide immunizations, especially influenza and pneumococcal vaccines, and

other services such as cholesterol screening, in a simple, expeditious fashion without the need to do eligibility determinations. Typically, these are circumstances where the health district is providing a streamlined, high-volume, low-cost service, and the goal is to serve as many people as possible in as simple and convenient a fashion as possible.

a. Health districts that provide services at special mass clinics by charging a flat rate must also offer an alternative method or venue whereby patients can obtain these services by paying a sliding scale charge (and Income Level A patients can receive these services at no charge).

b. The alternative sliding scale method must be provided with sufficient frequency and convenience that patients have a realistic alternative to obtaining them on a flat fee basis.

12VAC5-200-105. Charges for Services Provided by Contract

Establishment of Charges When Health Districts Partner with Other Agencies

Charges for clinical services and flat rate charges shall be governed by the Board of Health Regulations (12VAC5-200-10, 12VAC5-200-20, and 12VAC5-200-110) and this Guidance Document. In general, if a health district has primary operational control of a clinic or medical-care delivery arrangement, the Board of Health Regulations and this Guidance Document shall determine the charges.

If a health district contracts to provide medical care on behalf of an outside agency, and the charges or method of determining the charges are specified in the contract, the contract shall govern. If the contract does not specify the charges or how they are determined, the Board of Health Regulations and this Guidance Document shall determine the charges.

For other arrangements in which the health district contributes only partial support to an operation, other methods of determining patient charges are acceptable. However, health districts cannot charge, or allow patients to be charged, for services that they would normally provide free or at a reduced charge. These include services such as those provided under Section 12VAC5-200-150 (“Services Provided at No Charge to the Patient”). This prohibition applies only if the health district is actually providing these services in partnership with some other agency. It would not apply if the health district does not provide these services in a partnership arrangement. For example, a city operates an indigent medical center with some services provided by the health district. If the health district were not involved in the services provided in the center, the center could determine the charges for the services. If the health district were providing the services, the charges would be determined in accordance with applicable state law, Board of Health regulations, and this document.

This section does not restrict a district's ability to bill third-party insurance carriers for covered services, unless otherwise prohibited.

12VAC5-200-110. Income Levels for Charges

Clients of the Virginia Department of Health shall not be denied service or subjected to any variation in quality of service due to *inability* to pay. The agency's eligibility determination process has been designed to take the patient's ability to pay into account. Depending on income and applying annual federal poverty income guidelines, the agency determines whether the client should not be charged a fee (Income Level A) or whether the client is able to pay some percentage of the cost on a sliding scale, up to 100% (Income Levels B-G).

12VAC5-200-120. Automatic Eligibility

Applicants receiving the following public assistance program will receive services as Income Level A patients without additional income verification. If the documentation of one of the categories listed below is provided, no other financial information is necessary for a patient to receive services. However, it is important to obtain any insurance information so that the insurance companies may be billed for services provided. Documents required for automatic eligibility:

1. General Relief. Check stub or letter.

2. Medicaid/Medicaid MCO (Excluding FAMIS or Plan First). Current card or notice of eligibility, the person is listed on Medicaid's eligibility portal or other online eligibility verification system, or by a documented call to the Audio Response System (ARS). A copy of the card shall be made at the time of the eligibility determination, or the information on the card may be documented in the applicant's record. Similarly, information obtained from the Medicaid verification system or other online portal may be printed and filed in the applicant's record. Babies born to mothers on Medicaid may not receive automatic eligibility. Although the applicant may be covered by Medicaid, the remaining family members may not receive automatic eligibility status.

3. National School Lunch Program (for School Dental Services Only). The school must verify that the child is eligible for the free-lunch program. This eligibility applies only to students eligible for a free lunch and not to students eligible for a reduced lunch.

4. WIC Dental Varnish Program. If a child is eligible for the WIC program and is between the ages of six months to three years, he or she is automatically eligible for this program.

12VAC5-200-130. Explanation of Charges

To the extent possible, patients who are able to pay (i.e., in one of Income Levels B through G) should be advised of the estimated charges they will encounter and their payment responsibility at the time an appointment is made. Prior to services being rendered on the date of the appointment, an explanation of the estimated charges, applicable discounts, and expected payment shall be provided to the applicant.

Insurance Deductibles and Co-Payments

Deductibles. At the start of the benefit year, the insured patient may have charges from all providers applied to a deductible threshold before benefits can begin to be paid. At the time of service, VDH will not know whether a charge will be applied to a deductible because deductible amounts vary from plan to plan, and the VDH charges may or may not be dated after charges from other providers have met the deductible. If the VDH charge is not paid by the insurer because it is applied to the deductible, then the patient is responsible for paying the full amount due for the service as determined by the sliding scale.

Co-Payments. If the patient's insurance requires a co-payment, the patient is responsible for the payment as determined by the sliding scale. There is never a co-payment for family planning services or supplies under Medicaid.

Statement of Charges

When the services, tests and supplies have been rendered, the patient will be provided a detailed statement of charges and will be expected to pay the balance owed on the date of service, within thirty days of that date, or in accordance with the terms of a payment plan. A patient in one of Income Levels B through G who does not pay for the services, tests, or supplies at the time of the visit will be offered financial counseling, including the following information:

1. Clients who are able to pay are expected to pay for the services, tests, and supplies during the visit or, if they elect not to pay during the visit, within 30 days of the date of the visit.

2. The client has an opportunity to agree to a payment plan, permitting payments to be made in installments over a period of months instead of within 30 days.

3. If necessary, the district will work with patients to make arrangements to accept partial payments until the patient has paid all charges. If the client makes a partial payment of an amount due, the health department will

recognize it as a good-faith effort to pay and will suspend the initiation of debt set-off or collection actions until the next billing cycle.

4. State regulations require that delinquent accounts be referred to the Department of Taxation for debt set-off and to private agencies for collection.

5. If the client experiences a serious personal or family financial emergency, he or she may request a waiver of payments for ***new*** services, tests, and supplies. The health department may waive all or a portion of such payments for up to 180 days (a "financial waiver").

6. If the client has unusually serious health problems, the health department may waive all or a portion of payments for ***new*** services, tests, and supplies for up to 180 days (a "medical waiver").

7. Before taking any action to deny further services, tests, or supplies because of unpaid debts, the district will conduct a new eligibility review to determine whether the patient's income level should be changed. If a determination is made that the patient is unable to pay, the patient will be assigned to Income Level A and will continue to receive services and supplies without charge. If the eligibility review finds that the patient is still able to pay, the failure to pay will be deemed a refusal to pay.

8. Refusal to pay will be cause for denial of future services, tests, and supplies, unless a waiver of payment for the new services is approved as described in Part VI below.

9. If the patient is receiving ongoing medical care and a waiver has not been granted, the department will continue providing medical care and will make a good-faith effort to find alternative care.

The patient will be asked to sign a Form CHS-1C, Application and Agreement for Payment Plan, documenting this counseling. A patient shall not be denied future services, tests, and supplies unless this financial counseling has been provided.

<u>Billing, Refusal to Pay, and Collection</u>

This section is applicable only to patients ***who are able to pay*** as determined through the eligibility process (i.e., patients in Income Levels B through G).

Accounts receivable policies and procedures of VDH are in compliance with the Code of Virginia § 2.2-4800 et seq., "Policy of the Commonwealth; Collection of Accounts Receivable," which provides as follows:

> "…Each state agency and institution shall take all appropriate and cost-effective actions to aggressively collect its accounts receivable. Each agency and institution shall utilize, but not be limited to, the following collection techniques, according to the policies and procedures adopted by the Department of Accounts and the Attorney General: (i) credit reporting bureaus, (ii) collection agencies, (iii) garnishments, liens and judgments, and (iv) administrative offset…
>
> …Each state agency and institution shall develop internal policies and procedures, in accordance with accounts receivable policies of the Department of Accounts and the Attorney General, for delaying or withholding certain state services to those persons who refuse to pay their debts..."

Throughout the billing and collection process, patient contact and confidentiality requirements will be appropriately considered and addressed.

Bills to patients will include a disclosure to the effect that non-payment of the balance or any portion thereof may be cause for denial of future services and that delinquent accounts will be referred to the Department of Taxation for debt set-off and to private collection agencies.

Districts are encouraged to work with patients to make arrangements to accept partial payments until the patient has paid all charges. Alternative payment arrangements are acceptable. If the client makes a partial payment of an amount due, the health department will recognize it as a good-faith effort to pay and will suspend the initiation of debt set-off or collection actions until the next billing cycle.

If the patient fails to make the payment(s) as scheduled, the patient will be sent a "delinquent" bill with a notice that a refusal to pay the amount due, plus a late charge, may be cause for denial of future services, tests, and supplies or that payment for future services may be required in advance. The notice will urge the patient to contact the health department where the service was provided to discuss the matter with someone in the business office.

This business office discussion could form the basis for a new eligibility determination in accordance with 12VAC5-200-140, applying the most recent federal poverty income guidelines and/or a waiver by the district director of all or a portion of new charges for up to 180 days as provided in Part VI below. This discussion will be documented in the patient's record.

VDH staff should be alert to situations in which a waiver for medical reasons may be appropriate (e.g., a pregnant patient in a high-risk category), ***whether or not the patient requests such a waiver***. The district director shall be informed of such situations before services are denied.

If these alternate measures are not applicable and the overdue payment is not made within the next 30 days, the account will be referred to the Department of Taxation for debt set-off and to private collection agencies, and it will be written off in accordance with standard procedures.

Denial of Service

12VAC5-200-80 provides that:

> "Individuals who have failed to make any payment within the past 90 days for medical care services or other goods or services they have received may have their medical care services terminated. The district director may terminate services only following notice to the individual that such services will be terminated and only after determining that terminating services would not be detrimental to the individual's health. Medical care services cannot be terminated for individuals receiving ongoing care without making a good faith effort to secure alternative care."

If a patient in one of Income Levels B through G (including a patient in a Family Planning clinic funded in whole or in part by federal Title X grants) has refused to pay and the account has gone through the counseling, billing, and collection sequence described above, further services, tests, and supplies shall be provided only under the following circumstances:

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1. Clients with overdue bills are eligible for non-chargeable services and may not be denied such services.

2. For all other services, a new eligibility determination will be made, applying the latest federal poverty income guidelines. If the patient refuses or does not provide the necessary documentation, the new services, tests, or supplies will be denied.

3. If the eligibility determination establishes the patient is at Income Level A, (i.e., is unable to pay), the services, tests, and supplies will be rendered.

4. If the eligibility review determines that the patient is still at Income Levels B through G (i.e., is able to pay, but refuses to do so), the services, tests, and supplies will be denied. Alternatively, at the option of the district director or his/her designee, the patient shall be required to pay for new services, tests, and supplies in advance of receiving them.

As required by 12VAC5-200-80, the district will make a good-faith effort to find alternative care before denying continued service to patients. District directors may terminate services only when doing so would not be detrimental to the

individual's health. For example, in a Family Planning clinic, although further contraceptive services may be terminated, follow-up services for an abnormal Pap smear or other event with ongoing medical implications and consequences may not be denied unless an alternative provider for these treatments has been identified. District directors shall make this determination, and this responsibility shall not be delegated.

12VAC5-200-140. Redetermination of Eligibility

A new eligibility determination must be completed every 12 months or other frequency as required by a specific program. Eligibility determinations should also be completed when 1) The health district has reason to believe the patient's eligibility status, income, or family composition has changed, 2) The patient has an overdue account and denial of service is contemplated, or 3) A patient requests a waiver. A new CHS1-A must also be signed every 12 months or whenever eligibility is updated.

Part IV
Non-Chargeable Services

12VAC5-200-150. Services Provided at No Charge to the Patient

General

In accordance with the Code of Virginia (12VAC5-200-150), certain services are to be provided by health districts at no charge to Virginia residents. Because there is no charge, no eligibility determination is required. However, health districts may charge patients' health insurance providers. If the health insurance provider requires a co-payment, it will be collected based on the sliding scale.

Non-chargeable services are discussed in detail in the following sections. For reference purposes, the relevant sections of the code are 1) Immunization of Children, § 32.1-46; 2) Examination for Suspected Tuberculosis, § 32.1-50; 3) Sexually Transmitted Diseases, § 32.1-57; and 4) Ophthalmia Neonatorum, § 32.1-64. Please note that the following sections may additionally include diseases and services beyond those that are required in the Code, and their delivery or assurance of their availability is required of local health departments.

Immunizations

All immunizations required by the Code of Virginia for children or adolescents attending school through Grade 12 (per § 32.1-46) must be provided at no charge to the patient for the vaccine, vaccine administration, or vaccine handling. Currently, these immunizations include those against tetanus, diphtheria, pertussis, polio, measles, mumps, rubella, *Haemophilus* influenzae type B, pneumococcal infection, hepatitis B, and varicella. Occasionally, additional immunizations will be added to this list and must also be provided at no charge. For instance, § 32.1-46 states only that HPV vaccination is provided at no charge for females; however, VDH additionally provides it at no charge for males. Please consult VDH’s Office of Epidemiology, Division of Immunization for the most current list of required vaccines.

Patients may be charged at a flat rate for immunizations provided in a Travel Medicine clinic. However, if any of the immunizations required by the Code of Virginia are administered in a Travel Medicine clinic, there must be no charge to the traveler as long as the traveler is within the appropriate age group.

Routinely-recommended vaccines purchased under certain funding sources (e.g., state-funded free, 317) will be provided to uninsured/underinsured adults at no cost for the vaccine, even if the adults obtain these immunizations in a Travel Medicine clinic. Patients shall be charged an administration fee, but service cannot be denied because of the patient’s inability to pay the fee. Other chargeable travel-related services, however, must be deferred until a client is

able to pay. Please refer to the Vaccine Billing Policy for additional information. From time to time, additional vaccine initiatives may be implemented with separate procedures for determining applicable charges.

All other immunizations provided by the department may be charged to the patient. This includes charging for immunizations administered to children if the immunization is not required by Code of Virginia. Vaccines purchased on federal procurement contracts and provided to the health districts by the Division of Immunization must not be used for a chargeable service. Health districts must use local or co-op budget funds to purchase chargeable vaccines.

Tuberculosis

Virginia Code § 32.1-50 requires health departments to assess, examine, and test at no charge individuals suspected (i.e., presumed but not confirmed) of having, or known to have, tuberculosis disease. Assessment, examination, and testing may include nurse assessment, physical examination, chest x-rays, testing for TB infection, sputum collection and testing, or other tests. The district director or other appropriate authority shall determine which tests and procedures are appropriate for any given patient.

Examination and testing services are offered at no charge to contacts of a presumptive or confirmed TB case, a person with symptoms consistent with active TB disease, or an immigrant with TB classification.

Individuals assessed, examined, or tested for other purposes, e.g., as an employment-screening or school-entry requirement, may be charged for this service. Individuals in this category who test positive for TB infection (by blood or skin test), shall be charged for a chest x-ray in the absence of symptoms consistent with active TB disease.

Once a diagnosis of either TB disease or TB infection (previously known as latent tuberculosis infection [LTBI]) has been made, clients may be charged or their insurance billed for services. An income determination shall be completed to determine if the client is eligible for a sliding scale discount. The health district should charge a flat rate for drugs, laboratory tests (e.g., liver function tests), chest x-rays, and other tests or procedures needed to monitor treatment unless the district director elects to charge for them on a sliding scale. Clinic visits shall be charged on a sliding scale.

Health districts cannot charge patients for any services, laboratory tests, or x-rays paid for either directly or indirectly by the Office of Epidemiology (indicated by OEPI price codes). Health districts may not charge for providing the services of Directly Observed Therapy (DOT), Directly Observed Preventive Therapy (DOPT), or Video Enhanced Therapy (VET).

Patients with presumed or confirmed tuberculosis (active disease or infection) shall not be denied treatment for non-payment. To avoid collection actions for non-payment, clients should be encouraged to request a waiver if unable to pay.

See Waivers (pages 37-38) for more information, and see Appendix F for an algorithm that will help determine TB-related charges.

Sexually Transmitted Infections

When a district director, ***on a case-by-case basis****,* requires a person to receive treatment for sexually transmitted infections, no fee shall be charged if such person receives such treatment from the local health department (see § 32.1-57). As defined in § 32.1-55, venereal disease (sexually transmitted infections) includes syphilis, gonorrhea, chancroid, granuloma inguinale, lymphogranuloma venereum, and any other sexually transmitted infection determined by the Board to be dangerous to public health. This includes testing and treatment for chlamydia and testing and counseling for HIV when required by a district director. When testing and treatment is required as described above, there shall be no charge to the patient for venipuncture, administrative, or handling fees associated with the diagnosis and treatment of the sexually transmitted infections defined above.

Treatment for ophthalmia neonatorum, when the cause is ascertained to be gonococcus or chlamydia, shall be free of charge.

Consult the most current Referral/Non-chargeable STI Matrix for specific referral categories that also enable a patient to receive certain STI-related services at no cost.

12VAC5-200-160. Immunization Services

If the commissioner or a district director elects to provide free immunizations because of an actual or potential outbreak of a communicable disease, he or she should document in writing the rationale for such action. No specific format is prescribed; however, the document should include the actual or presumed etiologic agent of the outbreak, the evidence that an outbreak had occurred or might occur, an estimate of the magnitude of the actual or potential outbreak, the number of doses of vaccine provided and their cost, the method of mass immunization, evidence that the immunization program was effective (if available), and a discussion of alternative means (if any) to control the epidemic that did not involve providing free immunizations and a rationale for providing free immunizations. Documentation is not required for immunizations that are routinely provided at no cost to specific populations.

12VAC5-200-170. Other Health Care Services

If a district director elects or is directed to provide free medical care services to a substantial number of citizens as a group, he or she should document in writing the rationale or justification for this action. The documentation should include a description of the circumstances or medical problem, the rationale for this action or the direction by the commissioner to do so, the nature and extent of the services provided, the number of individuals served (with a demographic breakdown if available and appropriate), the cost of providing these services, and the outcomes of this action (if these can be determined).

Part V
Exceptions

12VAC5-200-180. Exceptions

12VAC5-200-190. Limitations

Residency Requirements

As a general rule, there is an expectation that VDH services will be provided to all clients who present for services, regardless of their residency. District directors shall request approval from the Deputy Commissioner for Community Health Services before restricting health services by legal residency, e.g., to residents of Virginia or to residents of the health district. Such restrictions may not impose a duration of residency, which is generally held to be a violation of the constitutional right to travel. Special rates or flat fees for non-residents shall not be established.

Residency requirements shall be governed by the following guidance:

1. If a service is fully funded by a grant or contract, residency restrictions may be imposed with approval by the deputy commissioner and to the extent authorized by the funding organization.

2. If a service is funded by state general funds and local match, and it is a mandated service, residency restrictions limiting service to Virginia residents may be imposed with approval of the deputy commissioner. Restriction to residence in a particular district or local jurisdiction is not permitted.

3. If a service is funded by state general funds and local match and is not mandated, residency restrictions limiting service to Virginia residents or residents of the health district may be imposed with approval of the deputy commissioner.

4. If a service is funded by 100% local funds, narrower residency restrictions (e.g., providing services only to locality residents) may be imposed, with approval of the deputy commissioner and in accordance with the wishes of the funding locality.

5. Except in the case of 100% locality-funded services, services shall not be restricted by residency to a lower geographic level than district-wide.

Proof of residence may be a Virginia driver's license, rent or mortgage payments, utility payments, voter registration, federal or state income tax forms, or any other document that establishes Virginia residency. Proof of residency may also be

established by meeting the requirements in this Guidance Document under Section 12VAC5-200-10, Gross Income, Proof of Income, 12-B.

12VAC5-200-200. Reserved

Part VI
Waiver of Charges

12VAC5-200-220. General

In instances where applicants or their immediate families have unusually serious health problems or an extraordinary financial hardship is demonstrated to exist, and there are no other avenues of care, the patient, guardian, or other authorized person may request a waiver of all or a portion of charges for up to 180 calendar days. A waiver must be requested in writing.

By regulation, the commissioner is designated to grant or deny waivers. The commissioner delegates this authority to district directors. This authority shall not be delegated further down the organizational structure.

12VAC5-200-230. Waivers

The waiver provides a 100% discount for all or a specified portion of medical care services for up to 180 days. The start of the initial waiver period will be the day the waiver request is received by the district. Balances owed prior to the waiver period may not be waived. When a waiver is requested, the health district may complete a new eligibility determination. If the applicant does not provide documentation to support the waiver request or eligibility determination, the applicant must provide it within 10 working days. If the needed documentation is not provided within 10 working days, the beginning date of the waiver will be moved to the date the documentation is provided and the applicant will be responsible for any charges incurred prior to the date of the waiver.

The waiver may be extended for periods of up to 180 days at the discretion of the district director. The applicant must reapply for a waiver and provide the same documentation required for the initial waiver before any reapplication can be granted. The applicant will be liable for any charges incurred between the expiration of a waiver and the approval of its reapplication.

No waivers will be issued to persons believed to be eligible for Medicaid, Medicare, or any state-sponsored medical insurance program for indigent persons until the applicant provides evidence that he or she has applied for them. Health district staff should review the eligibility information already provided or conduct a new eligibility determination to determine if the applicant may be eligible for one of these programs.

- An applicant or the applicant's immediate family will be determined to have unusually serious health problems when the family's total medical bills are $\geq$ 7.5% of the applicant's family's gross income. Medical bills may include office visits to medical facilities; medications; medical supplies and equipment; dental services; laboratory, radiographic, and other diagnostic

tests and procedures; surgery; hospitalization; home health care services; and outpatient treatment. In addition, the applicant may include travel expenses for transporting family members to medical appointments. If family members are transported in a family-owned car, the applicant may claim mileage as an expense at the current state rate for mileage reimbursement.

Medical expenses used to determine a waiver in one period may be used in the waiver calculations for subsequent periods. Each time an applicant applies for a waiver, he must present the billings that show his current outstanding indebtedness.

- Extraordinary financial hardship includes such causes as natural disasters, damage to or loss of uninsured real or personal property, unpaid legal liabilities, and obligatory and unavoidable expenditures for close relatives outside the family unit.

- Extraordinary financial hardship also includes unique circumstances in which careful, sensitive interviewing determines that a patient relies on others for payment of charges and those with the income refuse to pay for services. Examples of these circumstances are 1) adult patients whose spouse or companion refuses to pay for prior services being billed; and 2) minors in family planning clinics whose parents are aware of the clinic visits but refuse to pay for prior services being billed. In these situations, and if the district director approves, the patients may be permitted to request a waiver of new charges. As noted above, spouses, companions or parents will still be liable for payment of bills for prior services for which they are the guarantors.

If a district director waives all or a portion of the charges for medical care services, this decision should be documented in writing by the director and placed in the patient's medical record. The documentation should include a statement that all or a specific portion of the charges are waived for a specific period (which should be specified in the documentation) and a description of the circumstances that necessitate a waiver of the charges. If the waiver is reapplied for, there should be ongoing documentation of the need for charges to be waived, including a statement regarding the patient’s eligibility qualification(s).

Part VII
Appeal Process

12VAC5-200-270. Rights

A patient who wishes to appeal a decision regarding the delivery of medical care services should generally first appeal to the district director. If the services are provided through a specific program that has its own requirements, e.g., WIC or Every Woman's Life (EWL), the appeal should generally be made to director of the specific program. In the latter case, however, district directors should assist patients by providing them with the necessary information to make an appeal (e.g., name and contact information for the program director).

Part VIII
Fraud

12VAC5-200-280. Fraud

In cases where fraud is suspected, a new eligibility determination should be made and the patient charged accordingly. Previous charges should not be readjusted.

Where there is proof of willful misrepresentation and other agencies may also be misled, those agencies should be notified that the person may be defrauding them. Medical care services may be discontinued to the affected person 30 days after notifying the person in writing, by certified mail, that services will be discontinued.

APPENDIX A

Acronyms and Abbreviations

ARS	Audio Response System
CDC	Child Development Clinic
CHS	Community Health Services
CCC	Care Connection for Children
DNC	Do Not Contact
HIV	Human Immunodeficiency Virus
LES	Leave and Earnings Statement
SSI	Social Security Insurance
SSN	Social Security Number
STI	Sexually Transmitted Infections (replaces the term STD)
STD	Sexually Transmitted Diseases
VEC	Virginia Employment Commission
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX B

Sample Individual Statement

SELF DECLARATION OF "NO INCOME"

I, (Name of applicant), certify that I have no income.

I understand that "income" includes:

- pay, wages, or salaries
- tips
- unemployment benefits
- social security benefits
- welfare benefits
- disability, worker's compensation, or other payments for an injury or illness
- retirement or pension benefits
- alimony or child support payments
- insurance or annuity payments to me
- interest or dividends from savings accounts or investments
- rental income or other income from a business
- income from royalties, patents, gambling, or lottery winnings

I understand that if I have any of these types of income, I must tell the eligibility worker about them.

I have 30 days to give the health department a letter from a church, shelter, relative, or some other person who is providing my housing and meals. If I do not do this, I will be charged the full amount for any care the health department provides to me.

_____
(Signature of applicant or guardian)

_____
(Printed name of applicant or guardian)

_____
(Date)

APPENDIX C

Sample Agency Support Statement

STATEMENT MUST BE ON AGENCY LETTERHEAD STATIONERY*

We understand that (Name of applicant) is receiving medical care from the Virginia Department of Health. Because the applicant has no income, our agency is providing food and shelter for the applicant.

_____
(Signature of agency representative)

_____
(Printed name of agency representative)

_____
(Position at the agency)

_____
(Telephone number if not given above)

_____
(Date)

*See page 7, section 8-B-1, of this guidance document for exceptions.

APPENDIX D

Sample Relative or Friend Support Statement*

I understand that ___(Name of applicant)___ is receiving medical care from the Virginia Department of Health. Because the applicant has no income, I am either providing the applicant with food and shelter or providing the applicant with financial support.

_____
(Relationship to applicant - for example, friend, cousin)

I am providing _____ food and shelter, _____ financial support.

_____
(Approximate amount of financial support per month)

_____
(Signature of person providing support)

_____
(Printed name of person providing support)

_____
(Address)

_____
(Telephone number)

_____
(Date)

*See page 9, section 12-B for details on acceptable authentication of this letter.

APPENDIX E

Sample Individual Statement

SELF DECLARATION OF HOUSEHOLD INCOME

I, _____(Name of applicant)_____, understand that the amount I am charged for health department services depends on my household income. I understand that household income includes my income and the income of all family members living with me. If I do not live with a spouse or parents, I understand that household income includes the income of any companions, friends or relatives living with me who pool their income with mine or who pay all my living expenses.

I have the following income source(s) in my household:

- Gross (before taxes) Pay, wages or salaries $_____ (weekly, Bi-weekly, monthly, semi-monthly, yearly) for myself.
- Gross (before taxes) Pay, wages or salaries $_____ (weekly, Bi-weekly, monthly, semi-monthly, yearly) for other person(s) in my household.
- Financial Support from family/friend of $_____ (weekly, monthly)
- Alimony or child support payments $_____(weekly, bi-weekly, monthly)
- Tips $_____ (weekly, bi-weekly, monthly)
- Unemployment benefits $_____(weekly, monthly) for myself/for other person(s)
- Social Security benefits $_____ (weekly, monthly) for myself/for other person(s)
- Other Welfare benefits $_____ (weekly, monthly)
- Disability, workers compensation or other payments for an injury or illness $_____ monthly for myself/for other person(s)
- Rental income or other income from a business $_____ monthly
- Retirement or pension benefits $_____ (weekly, monthly)
- Insurance or annuity payments to me _____ (weekly, monthly)
- Interest or dividends from savings accounts or investments $_____ monthly
- Income from royalties, patents, gambling, or lottery winnings $ _____ weekly, monthly, annually

I understand that if the members of my household have any of these types of income, I must tell the eligibility worker about them and include the income in the estimate. The health department requests that I bring copies of pay stubs or other documents as proof of income, to verify how much I will have to pay for services.

I declare that my **total** estimated household income is $_____ weekly, biweekly, semi-monthly, monthly, yearly (circle one)

_____ _____

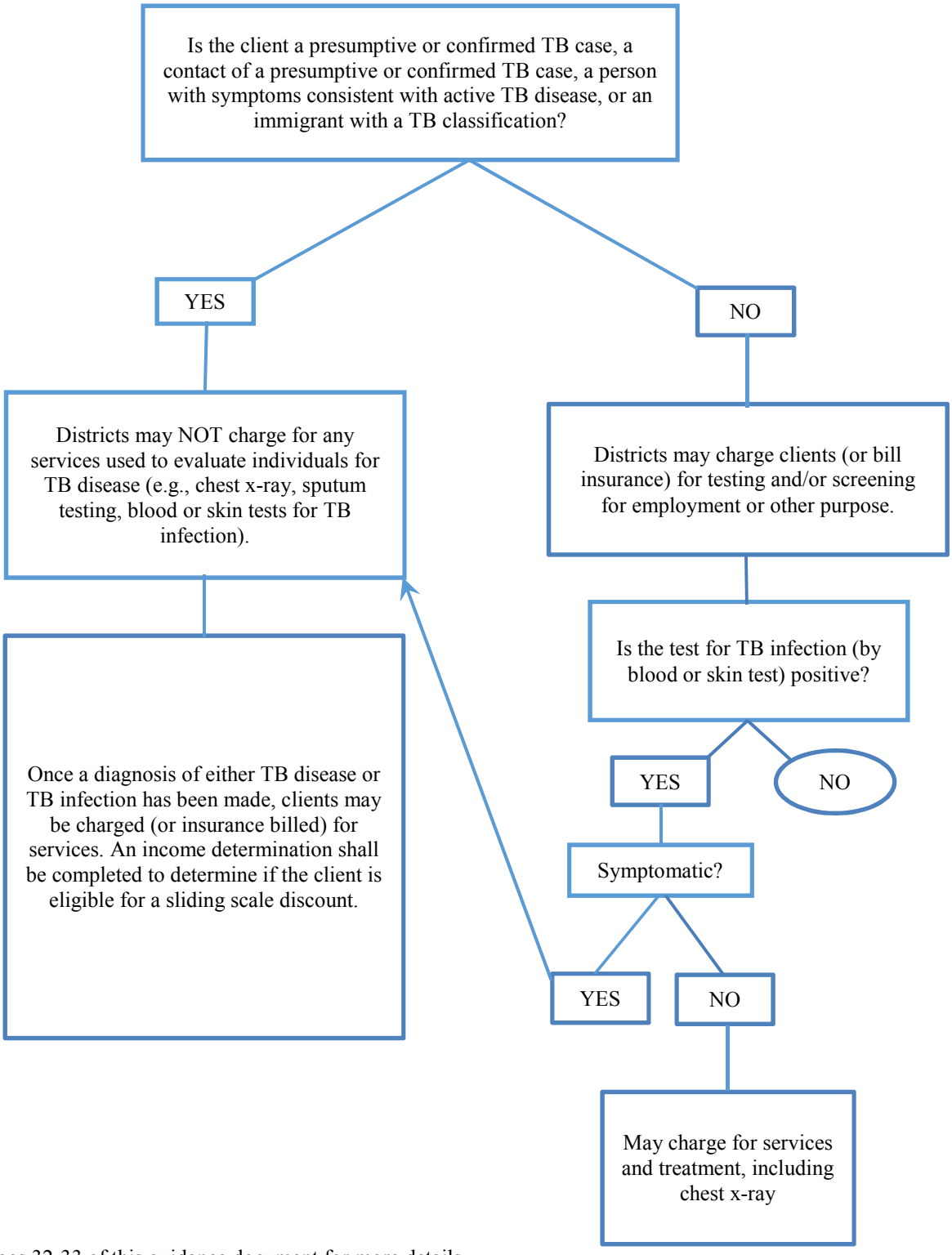
(Signature of applicant or guardian) Date

_____

(Printed name of applicant or guardian)

APPENDIX F

Algorithm for Determining Charges for TB Program



*See pages 32-33 of this guidance document for more details.

APPENDIX G

Health Director Guide for Discretionary Actions
Fees and Service Delivery

In general, all approved exceptions must be documented and maintained at the local health department.

General Eligibility

If a client is part of an economic unit that refuses to supply the client with necessary proof of income information for an eligibility determination to be completed, the district director or any other manager responsible for financial operations of the district (e.g., business manager or eligibility manager) may approve use of a self-declaration of household income without further requirement for proof of income from that economic unit. See pages 16-17 for details.

Flat Rate Charges

District directors have the authority to apply sliding scale discounts to goods or services for which flat rate charges have been approved. See pages 22-24 for details regarding flat rate charges.

A. If a given good or service is discounted, all patients must receive the sliding scale discount for the given good or service.

B. If a district director elects to charge according to the sliding scale, an eligibility determination must be done before providing these goods or services and must be offered to all patients.

C. District directors may discount all or only certain flat rate charges. In the latter instance, discounts shall apply to specific goods or services, or categories of goods or services (e.g., a specific class of pharmaceuticals), but not to individual patients.

D. If a district director elects to discount flat rate charges, this practice is not an acceptable basis for the district to operate at a deficit.

E. If a district director elects to discount flat rate charges, the decision to do so, along with the details of what goods, services, or categories of goods or services to be discounted, must be documented and signed by the current district director.

F. The commissioner or his designee reserves the right to require a district not to discount charges.

Denial of Service

The district director may terminate services to a client in certain circumstances, e.g., refusal to pay. See pages 29-30 for details.

Waivers

District directors may grant or deny a waiver of all or a portion of new charges up to a period of 180 days for a client who has unusually serious health problems or an extraordinary financial hardship and there are no other avenues of care. Waivers must be requested by the client in writing and shall not apply to previous balances. See pages 37-38 for details and documentation requirements.

Immunizations

A district director may elect to provide free immunizations because of an actual or potential outbreak of a communicable disease. See pages 31-32 for details.

Tuberculosis

Districts should charge a flat rate for drugs, laboratory tests, chest x-rays, and other tests or procedures needed to monitor treatment. District directors may elect to charge such items on a sliding scale. For details, see documentation requirements under Flat Rate Charges, E, and pages 32-33.

Other Health Care Services

A district director may elect to, or be directed to, provide free medical care services to a substantial number of citizens as a group. See page 34 for justification and documentation requirements.

Residency Requirements

A district director may, under certain conditions, restrict health services by legal residency, e.g., residents of Virginia or of the health district. All restrictions must be approved by the Deputy Commissioner for Community Health Services. See pages 35-36 for details.