



Documents available on the enclosed CD

Policies, Sample Forms, Toolkits, etc.:	Statutes and Regulations:
ADA Checklist for Existing Policies.pdf	18 USC 1591 Sex Trafficking of Children.pdf
Client Bill of Rights Sign.docx	42 CFR Part 50 Subpart B Consent Form.docx
Daisey Client Authorization Form.pdf	42 CFR Part 59 Subpart A.pdf
EHR Privacy and Security.pdf	45 CFR Part 74 HHS Grants Policy.pdf
KDHE Information Use Language.docx	45 CFR Part 74 Uniform Requirement.pdf
KDHE Information Use Notice 1.docx	45 CFR Part 80 Nondiscrimination civ.pdf
Sample Client Satisfaction Survey en.docx	45 CFR Part 84 Nondiscrimination di.pdf
Sample Client Satisfaction Survey sp.docx	45 CFR Part 91 Nondiscrimination ag.pdf
Sample Conflict of Interest Policy.docx	45 CFR Part 92 Uniform administrative.pdf
Sample Consent for Sterilization - en.pdf	Civil Rights and LEP Regulations.pdf
Sample Consent for Sterilization - sp.pdf	KSA 38-2223 Reporting Abuse or Neglect.docx
Sample Female Client Physical Exam.docx	KSA 65-1626 PHARMACY LAW.docx
Sample Female Health History - Spa.docx	KSA 65-1648 PHARMACY LAW.docx
Sample Female History.docx	Public Law 104-191 HIPPA Act of.pdf
Sample LEP Policy.docx	Public Law 106-386 The Trafficking V.pdf
Sample Male Client Physical Exam.docx	Public Law 111-148 Patient Protection.pdf
Sample Non-Discrimination Policy.docx	Title X Statute Public Health Service.pdf
Sample Staff Development Annual.docx	
Sample Translation Sign.docx	
Sample Voluntary Participation Lang.docx	
Title X Training Requirements.docx	
Training Checklist for Title X. docx	
Zikatoolkit.pdf	

340 B Program Participation Requirements

A. Background

The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations or covered entities (CEs) at significantly reduced prices. The Office of Pharmacy Affairs (OPA) is the Office responsible for administering the 340B Program and is part of Health Resources and Services Administration (HRSA). Federal law prohibits duplicate discounts, which means that manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. CEs must have procedures in place to prevent duplicate discounts. Other products available through the 340B pricing program include vaccines and diabetic supplies (lancets, meters, strips and syringes).

B. Definitions

- **340B Actual acquisition cost (340B AAC)** means the net cost of a drug paid by a CE for drugs or products purchased through the 340B drug pricing program. A drug or product's 340B AAC includes discounts, rebates, chargebacks and other adjustments to the price of the drug or product, but excludes dispensing fees.
- **340B CE** means a facility eligible to purchase drugs or products through the 340B Program and that appears on the OPA Database within the HRSA.
- **340B contract pharmacies** means a pharmacy under contract with a CE that lacks its own pharmacy whereby the contract pharmacy is authorized to dispense 340B- discounted drugs on behalf of the CE.
- **Fee-for-Service (FFS)** means providers bill Iowa Medicaid directly for prescriptions and physician administered drugs they provide to FFS members.
- **Medicaid Carve-In** means a CE has determined they will use 340B purchased drugs for Medicaid members.
- **Medicaid Carve-Out** means a CE has determined they will purchase drugs for Medicaid members through mechanisms other than 340B.
- **Outpatient Drugs** means drugs provided through individual prescriptions to a patient and physician administered drugs.
- **Physician administered drugs** means drugs billed as a physician service (i.e., billed with "J", "S", "Q", or other applicable HCPCS Level II procedure codes).

Additional definitions for acronyms and terms may be found at this site:

<https://opanet.hrsa.gov/opa/CoveredEntityAcronyms.aspx>

C. 340 B University

340 B University is an on-line educational resource for health care professionals working in the 340B field. The program's content has been reviewed and certified by the U.S. Health Resources and Services Administration (HRSA), as consistent with its interpretation of federal 340B policy: <https://www.apexus.com/solutions/education/pvp-education/340b-u-ondemand>.

D. Title X and 340B Program Requirements

To purchase drugs at the 340B price, covered entities must meet the following HRSA requirements:

1. Keep 340B database information accurate and up to date.
2. Recertify eligibility every year.
3. Prevent duplicate discounts. Manufacturers are prohibited from providing a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must accurately report how they bill Medicaid drugs on the Medicaid Exclusion File, as mandated by 42 USC 256b(a)(5)(A)(i).
4. Prevent diversion to ineligible patients. Covered entities must not resell or otherwise transfer 340B drugs to ineligible patients.
5. Prepare for program audits. Maintain auditable records documenting compliance with 340B Program requirements. Covered entities are subject to audit by manufacturers or the federal government. Any covered entity that fails to comply with 340B Program requirements may be liable to manufacturers for refunds of the discounts obtained.

Disproportionate Share Hospitals, freestanding cancer hospitals and children's hospital must also refrain from participating in a group purchasing organization for covered outpatient drugs.

It is the covered entity's responsibility to notify drug manufacturers and wholesalers that it will now purchase outpatient drugs at 340B prices. The wholesalers and manufacturers verify the covered entity's enrollment on the 340B database and must sell its drugs at or below the maximum price determined under the 340B statute.

E. Title X Program Requirements

1. Each agency must recertify annually any clinic sites where 340B purchased medications are used. Failure to recertify will result in the agency being unable to use 340B medications in any clinic sites that are not certified.
2. KDHE will confirm all Title X grant sub recipients and their related service sites are updated and certified via the Office of Pharmacy Affairs' electronic forms systems
3. Each sub-recipient must certify that reasonable safeguards are in place to assure compliance with the provisions of Section 340B of the Public Health Services Act that prohibit Drug Diversion and Double Discounts/Rebates.
4. Each sub-recipient will have a policy clearly describing their safeguards for Drug Diversion and Double Discounts/Rebates in their family planning manual. Sub-recipients will describe how they will maintain control over their inventory of 340B medications.

E. Implementation Options

HRSA does not specify how participants should implement the 340B Program. As long as participants comply with all 340B Program requirements, they have flexibility in implementing the 340B Program.

Most covered entities choose one or more of the following options:

- **In-House Pharmacy**, in which the covered entity owns drugs, pharmacy and license; purchases drugs; is fiscally responsible for the pharmacy; and pays pharmacy staff.
- **Contract Pharmacy Services**, in which the covered entity owns drugs; purchases drugs; pays (or arranges for patients to pay) dispensing fees to one or more contract pharmacies; and contracts with pharmacy to provide pharmacy services.
- **Provider/In-House Dispensing**, in which the covered entity owns drugs; employs providers licensed in the state to dispense; holds a license for dispensing for the participating providers; and is fiscally responsible for operating and dispensing costs.

F. Program Integrity

HRSA's Program Integrity guiding principles are to maximize oversight reach and manage compliance risks. HRSA's efforts to follow these principles include audits of covered entities and manufacturers to enforce requirements for these stakeholders. Other efforts include annual recertification in order to give covered entities an opportunity to review their 340B Drug Pricing Program (340B Program) responsibilities and re-attest to being currently in full compliance. Questionnaires are evaluated through HRSA grantee site-visits to serve as an initial screening tool for assessing compliance. Also, OPA's self-disclosure process allows covered entities to evaluate and correct aspects of their 340B Program through self-reporting.

G. Audits of Covered Entities

340B Drug Pricing Program covered entities must ensure program integrity and maintain accurate records documenting compliance with all 340B Program requirements.

HRSA has the authority to audit covered entities for compliance with 340B Drug Pricing Program (340B Program) requirements (42 USC 256b(a)(5)(C)):

H. Frequently Asked Questions

A list of Frequently Asked Questions (FAQ) is available through the 340b website: <https://www.340bpvp.com/resource-center/faqs/>

If you have specific questions, contact Apexus Answers (ApexusAnswers@340bpvp.com), who will provide assistance or connect you with a resource that can provide help.

340B AND MEDICAID: AN EXPLANATION FOR FAMILY PLANNING PROVIDERS

APRIL 2016

The intersection of the federal 340B drug pricing program and Medicaid is complex, leading to confusion among publicly funded family planning providers as to their rights and responsibilities with regard to the use of 340B drugs for their Medicaid patients. To help address this problem, this guide explains key aspects of the 340B program, outlines important elements of current federal law and guidance, and describes the potential variation between states with regard to how that law and guidance are being implemented to provide a practical understanding that will help providers maximize their benefit from the use of 340B drugs in Medicaid.

What Is the 340B Program and its Purpose?

The purpose of the 340B program is to allow safety-net providers to stretch scarce federal resources as far as possible to reach more eligible patients and provide more comprehensive services. The 340B program is administered by the Office of Pharmacy Affairs at the federal Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services. Federal law mandates that drug manufacturers provide discounts on their drugs to certain health centers, known as covered entities, which primarily serve low-income or medically underserved individuals. Covered entities are eligible for these discounts if they receive any one of a specified group of federal funding streams. Title X-funded health centers are among the covered entities that can receive these discounts. Other covered entities include federally qualified health centers (FQHCs) and FQHC look-alikes, Ryan White HIV/AIDS program grantees, children's hospitals, disproportionate share hospitals, and Section 318-funded sexually transmitted disease (STD) clinics. Accepting Medicaid patients does not, in and of itself, make a provider eligible for 340B, but Medicaid patients are not precluded from getting 340B drugs if they are receiving care through a covered entity and otherwise eligible under the 340B program. Therefore, Title X-funded health centers and other covered entities can and do use 340B drugs with Medicaid patients, but there are additional considerations which are outlined throughout this document.

How Does the Program Work?

Federal law sets a ceiling price for 340B drugs. Manufacturers may charge less than, but cannot exceed, this ceiling price. There are a variety of ways that a covered entity can purchase 340B-priced drugs, such as by purchasing directly from the

manufacturer or a wholesaler. One common route is for the covered entity to purchase the drugs through a group purchasing organization (GPO). Some notable examples of GPOs are:

- The Afaxys Group Services (AGS) GPO focuses solely on the needs of public health and safety-net providers, offering a diverse portfolio of discounted products and services. In addition to members-only 340B and non-340B pricing, the AGS GPO also has a relationship with MedAssets, a major national GPO, offering members access to MedAssets' expansive portfolio of offerings, including office supplies, medical supplies, equipment, and services. Membership to the AGS GPO is free and open to all safety-net providers.
- Apexus is a company contracted by HRSA's Office of Population Affairs to run the 340B prime vendor program. The prime vendor program negotiates discounts on 340B drugs and devices below the 340B ceiling price. To purchase drugs through the prime vendor program, a covered entity must be registered with the prime vendor. Membership is free and open to all 340B covered entities. The prime vendor also negotiates discounts for "value-added products" that are not 340B eligible, such as vaccines and condoms.
- California Family Health Council (CFHC), the Title X grantee in California, operates a co-op program in partnership with Council Connections, a nationwide GPO. The CFHC co-op is open to health care organizations, as well as social service, education, and hospitality organizations across the country, and membership is free. Participation in the CFHC co-op provides access to discounted 340B and non-340B priced drugs to all its members. 340B covered entities may become members of the co-op for free after completing a membership application.

Which Patients Can Receive the Discounted Drugs?

In order to receive a 340B drug, an individual must meet the three-pronged definition of an eligible patient established in HRSA guidance. The patient must:

1. Receive services from a health care professional employed by or in contract with the covered entity¹;
2. Have an established relationship with the covered entity, as demonstrated by the covered entity maintaining a medical record for the patient; and
3. Receive a service or services that are consistent with the grant by which the covered entity is eligible for 340B.

As long as an individual meets the eligible patient definition above, any drug provided to that patient can be a 340B drug, so long as the drug is a covered outpatient drug (more on that in the next section). In the Title X context, any patient that would be counted as a “family planning user” on the Family Planning Annual Report (FPAR) would potentially qualify as a 340B patient, depending on the specific circumstances of the services the patient receives at a particular visit.² For example, a patient presents at a Title X-funded health center for a well-woman visit and asks to initiate hormonal contraception, but upon examination, the patient is found to have an infection that requires antibiotics. The clinician performing the exam may use 340B drugs not only for that patient’s contraceptive method of choice, but also for the antibiotics necessary to treat the infection. The same is true for a patient interested in a drug to assist with smoking cessation.

In addition to meeting the definition of an eligible patient, the individual must receive services beyond just receiving a drug. For example, in the Title X context, emergency contraception provided to an individual on a walk-in basis (e.g. without an exam or other health care services provided) would not

¹ Other arrangements may include a “referral for consultation” arrangement, under which the responsibility for the care of the patient remains with the covered entity.

² For the FPAR, a “family planning user” is an individual who has at least one family planning encounter at a Title X service site during the reporting period. This is true regardless of whether the patient has commercial insurance coverage, Medicaid coverage, or is uninsured, and applies to both male and female clients.

A “family planning encounter” is documented, face-to-face contact between an individual and a family planning provider that takes place in a Title X service site with the outcome of providing family planning and related preventive health services to clients who want to avoid unintended pregnancies or achieve intended pregnancies. A written record of the service(s) provided during the family planning encounter must be documented in the client record. Any “family planning user” would qualify as a 340B patient.

Thus, a “family planning user” would always meet at least one of the three prongs of the 340B patient definition (having an established relationship as demonstrated by the maintaining of a medical record). However, whether the family planning user meets the other two prongs (concerning services received) would need to be determined on a visit-by-visit basis, depending on the specific services received at each visit.

constitute a “service” under the definition. Therefore, the individual would not be considered an eligible patient under those circumstances. However, providers may use 340B-priced drugs for refills, as long as the patient meets the 340B patient definition when the drug is originally prescribed.

When 340B drugs are given to patients that do not meet the above criteria, the covered entity has engaged in what is called “diversion.” Diversion is prohibited, so the covered entity may be liable for repayment of the cost of drugs used for this purpose. Audits will include a review of 340B drugs dispensed, patient records, and other information and materials to ensure that diversion has not occurred. HRSA auditors will specifically want to see stand-alone 340B policies and procedures that specifically address the prevention of diversion (giving 340B-priced drugs to patients that don’t meet the patient definition) and duplicate discount (see page 4 for more information on duplicate discount).

Which Drugs Can Be Discounted under 340B?

As stated previously, any drug can qualify as a 340B drug, as long as the following requirements are met:

1. The drug must meet the definition of a covered outpatient drug, as defined by the Medicaid statute;³ and
2. The individual receiving the drug must meet the definition of an eligible patient, as previously outlined.

How Do I Use 340B Drugs with Commercially Insured or Self-pay Patients?

A covered entity has the ability to set a reasonable and customary fee for each drug it dispenses above the actual cost to the covered entity for each drug in order to cover the associated overhead costs of dispensing drugs on-site. This amount is included in fee schedules that are used to bill claims to commercial insurers and self-pay patients. The source of a patient’s coverage has no bearing on her or his ability to meet the 340B patient definition (see below for more information).

How Do I Determine the Charge for Self-pay Patients?

Title X providers should refer to the Title X program requirements regarding the schedule of discounts for patients to determine how to charge self-pay patients for 340B drugs. The basic parameters are as follows: Self-pay patients whose income is at or below 100% of the federal poverty level (FPL) would not be charged for the drug. Patients whose income is more than 100% and up to 250% FPL should be charged the appropriate portion of the reasonable charge based on the pre-determined

³ Defined as: an FDA-approved prescription drug, an over-the-counter (OTC) drug that is written on a prescription, a biological product that can be dispensed only by a prescription (other than a vaccine), or FDA-approved insulin.

schedule of discounts. Self-pay patients with incomes above 250% FPL should be charged the full reasonable charge.

How Do You Determine What to Charge Commercial Insurers?

Title X-funded health centers have historically performed cost analyses of their programs, which often include data on the cost of acquiring the contraceptive methods themselves. Data from these cost analyses can be used to set an agency's rates in its fee schedule. Covered entities initiating contract negotiations with commercial insurers ideally should bring in data from their cost analyses and current fee schedules to help assess the adequacy of the insurer's proposed rates.⁴ Offering beneficiaries a robust network of providers is one tool for commercial insurers to remain competitive in the market. Therefore, it is in the best interest of the commercial insurer to offer providers in their network competitive reimbursement rates. These rates are not necessarily contingent upon the covered entity's specific acquisition costs.⁵

Can I Use 340B Drugs with Medicaid Patients?

Yes, 340B drugs can be used with Medicaid patients. However, there are multiple factors that may impact a covered entity's decision to use 340B drugs with their Medicaid patients. Medicaid law requires manufacturers to provide the state Medicaid agency with rebates on the purchase price of drugs for Medicaid patients. However, the manufacturer is not required to provide that rebate when the drug is sold at the discounted 340B price. "Duplicate discount" is the term used by HRSA to describe the situation in which a manufacturer pays a Medicaid rebate on a drug that was sold at a 340B price.

Covered entities that choose to use 340B drugs with their Medicaid patients play an important role in avoiding duplicate discounts. Covered entities should make sure they are in compliance with 340B guidance governing the prevention of duplicate discounts, which requires covered entities to inform the state Medicaid agency that they are using 340B drugs for Medicaid patients.

What Does "Carve-in" and "Carve-out" Mean?

HRSA guidance allows covered entities to choose whether or not to use 340B drugs for their Medicaid patients. When a covered entity chooses to use 340B drugs for their Medicaid patients, it is referred to as "carving in." Covered entities

that choose not to provide 340B drugs to Medicaid patients are "carving out." When the participating provider is a 340B covered entity, the state can only collect a rebate from manufacturers on drugs provided by that health center if it has chosen to carve out.

Can a State Dictate a 340B Covered Entity's Carve-in/Carve-out Choice?

Many interpret current law and guidance as prohibiting a state from dictating whether a covered entity carves in or out. However, some states have implemented policies requiring one or the other, either for all Medicaid patients or for Medicaid managed care patients.⁶ Thus, covered entities should check the Medicaid policies in their state to determine any requirements governing carving in or out.

Does the Covered Entity Have to Make Carve-in/Carve-out Decisions for All Medicaid Beneficiaries or Can it Be Done on a Case-by-case Basis?

For Medicaid fee-for-service patients, a covered entity must decide to make its decision about carving in or out for all its Medicaid patients. This is not currently a decision that can be made on a patient-by-patient or drug-by-drug basis. In fee-for-service Medicaid, covered entities that have chosen to carve-in must record their National Provider Identifier (NPI) numbers in the federal Medicaid Exclusion File during 340B registration⁷, which state Medicaid agencies and manufacturers reference to determine which drugs are eligible for a rebate.⁸ There is currently no guidance in effect concerning Medicaid managed care patients, other than that covered entities should work with their managed care organizations to determine a process for carving in or out.⁹

⁶ In its proposed omnibus guidance for the 340B program, HRSA has articulated that the choice to carve in or carve out should belong solely to the covered entity. Additionally, HRSA has proposed that covered entities should be able to make different choices regarding carving in or carving out for Medicaid MCO patients by payer or by site. The guidance would also allow covered entities to make a different election with respect to their fee-for-service and Medicaid managed care patients. However, this guidance has not been finalized and does not yet apply.

⁷ "A change to the Medicaid Exclusion File may be requested at any time, but changes do not take effect until the first day of the following quarter and only if approved by OPA before the time it takes the quarterly snapshot of carve-in/carve-out decisions."

⁸ This is a one-time action that providers have to do (unless they want to change their decision on carving in or carving out), not something that happens with each prescription or each patient.

⁹ The proposed omnibus guidance also addresses developing a process for avoiding duplicate discount for Medicaid MCO patients. HRSA has sought public comment on whether it would be feasible to use the Medicaid Exclusion File for MCO patients, or if there is another process that would work better.

⁴ New contracts with new commercial insurers are typically one year in length. At the end of the life of the contract, covered entities will have the opportunity to request rate increases.

⁵ NFPRHA has additional resources regarding contracting with third-party payers and revenue cycle management available at: https://www.nationalfamilyplanning.org/health_care_delivery/revenue_cycle.

How Do You Determine Which Is Right for Your Health Center?

The first consideration is whether your state has any requirements for carving in or out. If your state allows health centers to make their own decisions, then the determining factor should be based on which is the better financial choice for your health center. Answering that question requires consideration of multiple factors, such as:

1. The size of your health center's Medicaid population;
2. What drugs your health center is most frequently providing that population;
3. The differences in available pricing for 340B versus non-340B drugs;
4. Reimbursement rates and requirements for 340B versus non-340B drugs; and
5. Whether or not you dispense on site.

Does the Program Work Differently for Fee-for-service Versus Managed Care Patients?

Under both circumstances, if the covered entity provides a 340B drug to a Medicaid patient, the covered entity must let the state know so that the state does not collect a rebate from the manufacturer for that drug.

Currently, there is no official federal policy on how to avoid duplicate discounts in the Medicaid managed care context. States have been directed to work with providers and managed care organizations (MCOs) to develop a process. Covered entities should consult with their state Medicaid agency and the MCOs with which they have contracts to determine the rules in their state.

How Is the Reimbursement Rate for Fee-for-service Medicaid Patients Determined? Can States Require Providers to Bill at Actual Acquisition Cost for 340B Drugs?

In the recently released Medicaid Covered Outpatient Drug final rule¹, the Centers for Medicare and Medicaid Services are now requiring that all states base their reimbursement for Medicaid covered outpatient drugs in fee-for-service Medicaid (whether those drugs are purchased at a 340B price or not) on actual acquisition cost² plus a professional dispensing fee. Furthermore, the rule states that for 340B providers that carve-in, the reimbursement from the state shall not exceed the 340B ceiling price. For 340B providers carving out, the

reimbursement shall not exceed the actual acquisition cost. States have the flexibility to provide different professional dispensing fees to different types of providers, so there is an opportunity for 340B providers to advocate for enhanced dispensing fees moving forward.

For more information on the 340B program, please visit the NFPRHA website, nationalfamilyplanning.org.

¹ The final rule is available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-01/pdf/2016-01274.pdf>.

² In this context, AAC is actually an aggregate price determined by the state based on one of several different methodologies, not necessarily the price each individual provider is paying.

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BILLING AND COLLECTIONS POLICY AND PROCEDURES

1. NO SERVICE DENIAL

A patient shall not be denied services or be subjected to any variation in quality of services because of an inability to pay.

2. CONFIDENTIALITY

Patient confidentiality shall not be jeopardized by any billing or collection procedures.

Procedures

- a) Bills shall not be mailed directly to confidential patients.
- b) Past due accounts for confidential patients may not be referred to a collection agency.

3. SCHEDULE OF FEES

Local agencies must establish a schedule of fees (charges) for all services and supplies. This schedule of discounts, based on the reasonable cost of providing services, should be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service.

Procedures

- a) Each sub-recipient shall at least annually review its fee schedule, which shall be based upon total program costs and cost analysis.
- b) Every service and supply provided by the agency must be included on the schedule of fees and discounts.
- c) A cost analysis must be conducted a minimum of every three years. KDHE may require a cost analysis more often if warranted.
- d) Each sub-recipient shall compare its fees to those of other community resources, and shall establish a fee schedule that is competitive.
- e) The fee schedule should be approved by the governing board, and must be submitted to KDHE for review by July 15th of each year.

4. SCHEDULE OF DISCOUNTS

Each sub-recipient should establish a schedule of discounts for client fees based upon the client's ability to pay.

Procedures

- a) A schedule of discounts is required for individuals with family incomes between 101% and 250% of the Federal poverty level based on family size, income and other specified economic considerations.
- b) No charge will be made for services provided, including the provision of contraceptives or related medical services, to any client at-or-below 100% of the federal poverty level except to the extent that payment will be made by a third party
- c) Fees must be waived for clients with family incomes above 100% of the federal poverty level who, as determined by the service site project director, are unable, for good cause, to pay for family planning services. A schedule of discounts is to be designed so as to maximize program income.

(Schedule of Discount Continued)

- d) Client eligibility for a discount must be documented in the client's record and should include income, family size, the level of discount, as applicable, the source of income verification and who completed the actual calculation by signing and dating the document. If staff prefers to initial documentation, then a legend should be available that identifies the staff name and initials.
- e) The sub-recipient shall not have a general policy of no fee or flat fees for the provision of services to minors or have a schedule of fees for minors that is different from other populations receiving family planning services.
- f) Fees to confidential adolescents shall be based on their own income.
- g) Individuals whose household income exceeds 250% of the poverty level shall pay full fee
- h) The Schedule of discounts should be updated annually.

5. PATIENT BILLING

Bills will be provided to clients or to eligible third-party reimbursement sources

Procedures

- a) The client's bill will include total charges, less discounts applied (if any) and the amount to be paid by the client.
- b) All client balances must be on a sliding fee scale, including those submitted to insurance and either found to be the "patient's responsibility" or simply not covered or paid at all.

6. BILLING AND COLLECTIONS POLICY ACCESS

The local agency will establish a written fee collection policy which will be applied consistently for all family planning clients.

Procedures

1. The agency shall provide, upon request, written materials which summarize the fee schedule and other salient policies and procedures.
2. The policy will include a list of reasonable efforts made to collect outstanding client balances.
3. Under no circumstances shall client confidentiality be jeopardized.

7. BILLING AND THIRD-PARTY REIMBURSEMENT

Local agencies must bill all third parties legally obligated to pay for services, except for those clients who have requested confidentiality.

Procedure

- a) Each sub-recipient will enter into a formal agreement with Medicaid.
- b) Each sub-recipient will apply for private insurance contracts.
- c) Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement with KanCare providers is required
- d) Each sub-recipient shall follow up on any claims denied or pending by third party payors.
- e) Bills to third parties will show total charges with no discounts.

(Billing and Third-Part Reimbursement Continued)

- f) Family income should be assessed before determining whether co-payments or additional fees are charged. With regard to insured clients, clients whose income is at or below 250% of FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.
- g) Confidential clients (regardless of age) should be informed that an EOB will be sent to the primary insured and if this is an impediment to confidentiality, their insurance must not be billed.

8. INABILITY TO PAY

Patients who are not able to pay their bills at the time of service must be provided services.

Procedures

- a) Patients unable to pay in full at the time of service may be asked to make a partial payment; at a minimum the cost of the supplies
- b) For a patient with a total account due in excess of \$50, staff may begin negotiating a payment schedule over time.
- c) Management will evaluate the need to waive fees of individuals with family incomes above 100% of FP who for good cause, are unable to pay but do not qualify for the schedule of discounts.

9. AGING OUTSTANDING ACCOUNTS AND USE OF COLLECTIONS AGENCY

Local agency use of a collection agency to obtain non-paid client fees should only occur under special circumstances and under the following conditions:

- a) Neither confidential adolescent clients' nor confidential adult clients' accounts may be sent to a collection agency.
- b) If the local agency elects to use a collection agency, clients must be informed of such when they make their appointment or when they enter the clinic.
- c) At the time of services, provide the client a bill/receipt/statement of services.
- d) Local agencies must have a written policy that indicates under what circumstances clients' accounts may be sent to a collection agency. Said policy must include but is not limited to:
 - 1) Informing clients of the availability of a sliding fee scale and encouraging clients to make a payment at the time the services are rendered.
 - 2) Providing clients with verbal and written notification of agency's policy/procedure regarding use of a collection agency.
 - 3) Handing the client a statement or bill at the time of service showing full charges, eligible discounts and amount owed. This policy applies to all clients whether the account balance is paid in full or not.
 - 4) A minimum of three (3) monthly statements are sent to the client with an outstanding account. Neither monthly statements nor bills/statement of services must ever be sent to a confidential client's home.
 - 5) When there is no response to the monthly statements:
 - Attempt to discuss the situation with the client;

(Aging Outstanding Accounts and Collections Continued)

- Reassess the client's income information, including the ability to pay, waiving the balance if warranted; and/or
 - Establish a payment plan
- 6) If a payment plan is established, at a minimum the client will be notified twice of the established payment plan and encouraged to pay accordingly if the payment plan is not honored within 30 days.
 - 7) If there is no effort to make payment on an outstanding account, the client is provided written notification in advance that the account may be sent to a collection agency.
 - 8) The account is sent to a collection agency if the client refuses to set up a payment plan.
 - 9) Documentation of all communications related to an outstanding account must be included in the client's financial record.

10. UNCOLLECTABLE ACCOUNTS

Receivable accounts deemed uncollectable will be written off as bad debts.

Procedures

- a) Agencies must have a "bad debt" policy for accounts with outstanding balances after a maximum of one year.
- b) An identified uncollectable account should be written off after no later than one year.

11. AGING OUTSTANDING ACCOUNTS

All billings and collections policies and procedures are subject to review by KDHE

Procedures

- a) If an agency uses a collection agency, clients must be informed of such when they make their appointment or when they enter the clinic.
- b) Bills may never be sent to confidential client homes.
- c) The agency must have a written policy that indicates under what circumstances client bills are sent to a collection agency. Policies must include:
 - 1) Informing clients when they may have to pay for some or all of their services when they make the appointment
 - 2) Sending at least three monthly statements to the clients with unpaid balances
 - 3) Attempting to discuss the situation and to set up a payment plan when there is no response to monthly statements
 - 4) Determining the payment plan and reassessing the client's ability to pay. Forgive the balance accordingly
 - 5) Notifying the client twice about the plan and encourage the client to pay if the payment plan is not honored within 30 days
 - 6) Indicating in the second notification that if there is no effort to pay the account balance within 30 days, the account may be sent to a collection agency
 - 7) Sending the account to a collection agency if the client refuses to set up a payment plan
 - 8) Documenting all communications about unpaid account balances

Commonly Asked Questions and Answers

Regarding the Protection of Limited English Proficient (LEP) Individuals under Title VI of the Civil Rights Act of 1964 and Title VI Regulations

1. Why are LEP individuals protected from national origin discrimination under Title VI?

The Supreme Court decided over three decades ago that a federal fund recipient's denial of an education to a group of non-English speakers violated Title VI and its implementing regulations. *Lau v. Nichols*, 414 U.S. 563, 569 (1974). As the Court explained, “[i]t seems obvious that the Chinese-speaking minority receive fewer benefits than the English-speaking majority from respondents’ school system which denies them a meaningful opportunity to participate in the educational program—all earmarks of the discrimination banned by” Title VI regulations. *Id.* at 568; see also *id.* at 570-71 (Stewart, J., concurring in result).

2. Does the failure by a recipient to provide meaningful access to LEP persons constitute national origin discrimination?

Since the Supreme Court’s decision in *Lau*, other courts have found that the failure by a recipient to provide meaningful access to LEP persons constitutes national origin discrimination. See, e.g., *Sandoval v. Hagan*, 197 F.3d 484, 510-11 (11th Cir. 1999) (holding that English-only policy for driver’s license applications constituted national origin discrimination under Title VI), *rev’d on other grounds*, 532 U.S. 275 (2001); *Almendares v. Palmer*, 284 F. Supp. 2d 799, 808 (N.D. Ohio 2003) (holding that allegations of failure to ensure bilingual services in a food stamp program could constitute a violation of Title VI).

3. Do Department of Justice (DOJ) Title VI implementing regulations prohibit both intentional discrimination and practices that have a discriminatory impact?

Yes. DOJ’s Title VI implementing regulations prohibit not only intentional discrimination but also facially-neutral practices that have a discriminatory impact, see 28 C.F.R. § 42.104(b)(2). The “failure to ensure that LEP persons can effectively participate in or benefit from Federally assisted programs and activities” may constitute national origin discrimination. U.S. Dept. of Justice, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 67 Fed. Reg. 41,455, 41,457 (June 18, 2002).

4. Do other federal agencies have Title VI regulations that prohibit both intentional discrimination and practices that have a discriminatory impact?

Yes. Federal agencies have implemented Title VI regulations that follow the DOJ regulations and have consistently construed Title VI’s prohibition on both intentional and disparate-impact discrimination to require that recipients of federal financial assistance provide meaningful access for LEP persons. See, e.g., 28 C.F.R. § 42.405(d)(1); Department of Health and Human Services (HHS) Notice, 35 Fed. Reg. 11,595 (1970); 45 Fed. Reg. 82,972 (1980); Executive Order 13,166, 65 Fed. Reg. 50,121 (Aug. 11, 2000).

Collecting Co-Pays and Applying Sliding Fee Scales

A Job Aid for Front Desk Staff

5 STEPS FOR COLLECTING CO-PAYS AND APPLYING THE SLIDING FEE SCALE

- 1: Find out the client's income, family size and whether she/he has insurance.
- 2: Check the client's insurance eligibility and determine the client's co-pay amount based on her/his insurance plan.
- 3: Determine where the client's income puts her/him on the sliding fee scale.
- 4: If the co-pay is less than the client would pay on the sliding fee scale, she/he should pay the co-pay, and the agency should bill the insurance company the fee for the services.
- 5: If the co-pay is more than what the client would pay based on the sliding fee scale, the client pays what she/he would pay based on the sliding fee scale, and the agency should bill the insurance company the fee for the services.

REMEMBER!

Clients should never pay more than what they owe based on the sliding fee scale.

HOW IT WORKS

Below is a sample sliding fee scale and two scenarios to show how to determine the co-pay when the client has insurance. Your agency's scale may be different since each agency has its own sliding fee scale.

Sample Client:

- Your client's income is \$25,000/year.
- She has two children.
- She has insurance. Her co-pay is \$20.
- To apply the sliding fee scale, first, match her income to your sliding fee scale.
- The sliding fee scale will show you the discount she would receive. In this situation, her discount would be 80%.

Family Size	Federal Poverty Levels 2014									
	100%	120%	140%	160%	180%	200%	220%	240%	250%	
1	\$11,670	\$14,004	\$16,338	\$18,672	\$21,006	\$23,340	\$25,674	\$28,008	\$29,175	
2	\$15,730	\$18,876	\$22,022	\$25,168	\$28,314	\$31,460	\$34,606	\$37,752	\$39,325	
3	\$19,790	\$23,748	\$27,706	\$31,664	\$35,622	\$39,580	\$43,538	\$47,496	\$49,475	
4	\$23,850	\$28,620	\$33,390	\$38,160	\$42,930	\$47,700	\$52,470	\$57,240	\$59,625	
5	\$27,910	\$33,492	\$39,074	\$44,656	\$50,238	\$55,820	\$61,402	\$66,984	\$69,775	
6	\$31,970	\$38,364	\$44,758	\$51,152	\$57,546	\$63,940	\$70,334	\$76,728	\$79,925	
7	\$36,030	\$43,236	\$50,442	\$57,648	\$64,854	\$72,060	\$79,266	\$86,472	\$90,075	
8	\$40,090	\$48,108	\$56,126	\$64,144	\$72,162	\$80,180	\$88,198	\$96,216	\$100,225	
9+	For families with more than 8 people, add \$4,060 for each additional person									
	100%	90%	80%	70%	60%	50%	40%	20%	10%	
	Discount									

Reference: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Available at <http://aspe.hhs.gov/poverty/14poverty.cfm>

SCENARIO 1:

- If fee for services = \$125
- With 80% discount, fee = \$25
- Insurance co-pay = \$20
- Client pays \$20
- Bill client's insurance the full fee
- Insurance co-pay is less than the fee, client pays the co-pay

SCENARIO 2:

- If fee for services = \$60
- With 80% discount, fee = \$12
- Insurance co-pay = \$20
- Client pays \$12
- Bill client's insurance the full fee
- Discounted fee is less than the co-pay, client pays the discounted fee

REMEMBER!

If the client requests confidential services, do not bill the insurance company.

Collecting Co-Pays and Applying Sliding Fee Scales

A Job Aid for Front Desk Staff

FREQUENTLY ASKED QUESTIONS: COLLECTING CO-PAYS AND APPLYING THE SLIDING FEE SCALE

Q: Our insurance contract says that we need to charge a specific co-pay. What can we do about this if the client's discounted fee is less than the co-pay?

A: No matter what, the client should be charged the lesser of the two: the co-pay or the discounted fee based on the sliding fee scale. The agency should submit the full charge for the service to the insurance company.

Q: What is the federal rule that applies to collecting co-pays and applying the sliding fee scale?

A: Title X [Program Requirements](#) provide guidance on how clients should be charged. Family income should be assessed before determining whether co-pays or additional fees are charged. With regard to insured clients, clients whose family income is at or below 250% of the Federal Poverty Level (FPL) should not pay more (in co-pays or additional fees) than what they would otherwise pay when the sliding fee scale is applied. Fees must be waived for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services. (See page 13, [Program Requirements for Title X Funded Family Planning Projects](#)). These rules apply to all client whether or not the client has insurance.

Q: Often clients with insurance do not want to tell us their income. What should we do?

A: Reassure your client that the reason you are asking for her/his income is because your agency's financial policy uses a sliding fee scale based on client's income and family size and that she/he may be eligible to pay less than her/his co-pay if the discounted fee is LESS than her/his co-pay. If the discounted fee is not less, she/he will only be charged the co-pay.

Q: How should we charge clients if they will not tell us their income?

A: Per the Title X [Program Requirements](#) (page 12), Title X agencies should follow their grantee's written policy on income verification and ensure that all clients are treated equally according to the policy. Check your grantee agency's policies regarding how to handle this situation.

HUMAN TRAFFICKING POLICY AND PROCEDURES

1. POLICY

Family planning project staff is required to comply with all applicable Federal laws including those related to human trafficking. Human trafficking is defined as “the recruitment, harboring, transportation, provision, or obtaining a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery¹.” Project staff must be aware that family planning clients may be victims of human trafficking and should be alert to possible indications a client is a victim of human trafficking. When requested by the victim, staff should offer victims information about human trafficking and should assist identifying resources for help.

2. PROCEDURES

- a) The provision of initial training opportunities on Human Trafficking with updates yearly for appropriate program personnel
- b) Documentation of completed training in each staff file.
- c) Agencies and their employees must comply with all state and federal reporting laws.
- d). Agency and staff should be proactive and develop a plan of action to deal with victims of human trafficking.

- 1) Procedure for referral in place.

If staff thinks they have encountered a victim of human trafficking, they should call:

National Human Trafficking Resource Center at 888-373-7888.

This hotline will help them determine if they have encountered victims of human trafficking, will identify local resources available in their community to help victims, and will help staff coordinate with local social service organizations to help protect and serve victims so they can begin the process of restoring their lives

- 2) Develop a list of resources
- 3) Have informational handouts available where possible victim can discreetly pick them up
- 4) Be sensitive that each situation is unique
- 5) Establish a relationship with local law enforcement and determine their policy on human trafficking
- 6) Review agency’s safety measures and policies with staff¹

¹ ACOG Committee Opinion, No. 507, September 2011, Human Trafficking

3. IDENTIFYING AND TREATING HUMAN TRAFFICKING VICTIMS

a) Human trafficking occurs in two forms:

Sex Trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act, in which a commercial sex act is induced by force, fraud, or coercion, or in which the person forced to perform such an act is under the age of 18 years.

Labor Trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery.

b) Common health issues in victims of human trafficking

- 1) Sexually transmitted diseases, HIV/AIDS, pelvic pain, rectal trauma and urinary difficulties from working in the sex industry
- 2) Pregnancy, resulting from rape or prostitution
- 3) Infertility from chronic untreated sexually transmitted infections or botched or unsafe abortions
- 4) Infections or mutilations caused by unsanitary and dangerous medical procedures performed by the trafficker's so-called "doctor."
- 5) Chronic back, hearing, cardiovascular or respiratory problems from endless days toiling in dangerous agriculture, sweatshop or construction conditions
- 6) Weak eyes and other eye problems from working in dimly lit sweatshops
- 7) Malnourishment and serious dental problems (These are especially acute with child trafficking victims who often suffer from retarded growth and poorly formed or rotted teeth.)
- 8) Infectious diseases like tuberculosis.
- 9) Undetected or untreated diseases, such as diabetes or cancer
- 10) Bruises, scars and other signs of physical abuse and torture (Sex-industry victims are often beaten in areas that will not damage their outward appearance, like their lower back.)
- 11) Substance abuse problems or addictions either from being coerced into drug use by their traffickers or by turning to substance abuse to help cope with or mentally escape their desperate situations.
- 12) Psychological trauma from daily mental abuse and torture, including depression, stress-related disorders, disorientation, confusion, phobias and panic attacks
- 13) Feelings of helplessness, shame, humiliation, shock, denial or disbelief
- 14) Cultural shock from finding themselves in a strange country²

² http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/health_problems.html

c). Screening Questions

Most victims of trafficking experience intense fear of their traffickers and of being deported. Avoid initiating a conversation with a potential victim of human trafficking by directly asking questions similar to these; “are you being beaten” or “are you being held against your will.”

Begin at the edge of the victim’s experiences. If available, use an interpreter not known to the possible victim or persons accompanying the possible victim. Any conversation with the possible victim should be conducted in private.

- 1) Can you leave your job or situation if you want?
- 2) Can you come and go as you please?
- 3) Have you been threatened if you try to leave?
- 4) Have you been physically harmed in any way?
- 5) What are your working or living conditions like?
- 6) Where do you sleep and eat?
- 7) Do you sleep in a bed, on a cot or on the floor?
- 8) Have you ever been deprived of food, water, sleep or medical care?
- 9) Do you have to ask permission to eat, sleep or go to the bathroom?
- 10) Are there locks on your doors and windows so you cannot get out?
- 11) Has anyone threatened your family?
- 12) Has your identification or documentation been taken from you?
- 13) Is anyone forcing you to do anything that you do not want to do? ³

d). Messages for Communication with Human Trafficking Victims:

Most victims of trafficking experience intense fear of their traffickers and of being deported. Gaining the trust of trafficking victims is an important first step in providing assistance. The US Department of Health and Human Services provided the following as possible messages to communicate to a victim of human trafficking. When communicating with a possible victim only convey messages that you are sure you can provide.

- 1) We are here to help you.
- 2) Our first priority is your safety.
- 3) Under the Trafficking Victims Protection Act of 2000, victims of trafficking can apply for special visas or could receive other forms of immigration relief.
- 4) We will give you the medical care that you need.

³ http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/screen_questions.html

- 5) We can find you a safe place to stay.
 - 6) You have a right to live without being abused.
 - 7) You deserve the chance to become self-sufficient and independent.
 - 8) We can help get you what you need.
 - 9) We can help to protect your family.
 - 10) You can trust me.
 - 11) We want to make sure what happened to you does not happen to anyone else.
 - 12) You have rights.
 - 13) If you are a victim of trafficking, you can receive help to rebuild your life safely in this country.⁴
- e) Understanding the victim's mindset
- Due to mistrust and fear, some victims of human trafficking will decline offers of assistance out of concern for their personal safety, and safety of family and friends. In such cases, the victim's wishes should be respected. **However if the suspected victim is < 18 years of age Mandatory Reporting laws apply.**
- 1) Many trafficking victims do not speak English and do not understand American culture. Preying upon the poor and destitute from countries in Eastern Europe, Asia, Latin America and Africa, traffickers lure their victims into the United States with promises of marriage, a good job so they can provide for their families back home, and a better life.
 - 2) These victims find themselves trapped in the sex industry, the service industry, in sweatshops or in agricultural fields – living daily with inhumane treatment, physical and mental abuse, and threats to themselves or their families back home.
 - 3) Victims of trafficking have a fear or distrust of the government and police because they are afraid of being deported or because they come from countries where law enforcement is corrupt and feared.
 - 4) Confidentiality is vital for victims of human trafficking. Their lives and the lives of their families are often at great risk if they try to escape their servitude or initiate criminal investigations against their captors. Therefore, it is imperative that you minimize the number of staff members who come in contact with the victim. Ensure that all staff members who have contact with the victim, including interpreters and advocates, understand the importance of confidentiality for the safety of the patient.
 - 5) Many victims do not self-identify as victims. They also do not see themselves as people who are homeless or drug addicts who rely on shelters or assistance. Victims may not appear to need social services because they have a place to live, food to eat, medical care and what they think is a paying job.⁵

⁴ http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/comm_victims.html

⁵ http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/mindset_victim.html

INCOME DETERMINATION GUIDELINES

Agencies will have a written policy in place about income determination. Agencies may choose to require income verification for the Title X project. If the agency requires income verification for Title X clients it must require income verification on all clients, including those presenting with payor plans. For the purpose of this policy income determination refers to the process of establishing client income to determine client placement on the schedule of discounts. Income verification means requiring the client to provide proof of income. The policy will reflect the following guidelines:

1. Income information shall be obtained from every client, documented, and updated annually. All clients will have income determination performed. No category or group of clients (for example teens, students, and Medicaid recipients) shall be excluded from income determination solely based on the client's membership in that group. Everyone who is a Title X user must be placed on a sliding fee scale regardless of whether or not they have a third party payer.
2. Clients who choose not to provide information regarding income must sign a release stating that they are choosing not to participate and agree that they will be charged full fee for services (if the client is responsible for payment of services).
3. Clients who report family income but are unwilling to provide income verification may be charged full fee. Clients must be informed that failure to provide proof of income where available may result in full fees being applied (if the client is responsible for payment of services). Clients must sign an acknowledgement of this obligation. This only applies in agencies requiring income verification.
4. Clients who report family income but are unable to provide income verification (teen babysitting money, spouse does not share income information) may be helped to estimate income. Agencies will document why proof of income is not available.
5. Clients who report they have no income are not required to prove absence of income, but may be asked about how they pay for living expenses. Clients can be asked to provide a letter or statement as to how they pay for their expenses.
6. Depreciation for self employment: If depreciation keeps the client from eligibility on the Medicaid Family Planning Waiver, depreciation must be disregarded for Title X placement.
7. Fees must be waived for any client with family incomes above 100% of the Federal Poverty Level (FPL) as determined by the service site project director or their designee, are unable, for good cause, to pay for family planning services.
8. When considering charges to minors for services, several conditions must be taken into account:
 - a. If the minor is unemancipated and confidentiality of services is **not** a concern, the family's income must be considered in determining the charge for the services. When a minor requests confidential services, without the involvement of a principal family member, charges for services must be based on the minor's income.
 - b. It is not allowable to have a general policy of no fee or flat fees for the provision of services to minors. Nor is it allowable to have a schedule of fees for minors that is different from other populations receiving family planning services.

Income shall be calculated using the following definitions:

Family and Household are used interchangeably and defined as individuals, related or nonrelated, living together as one economic unit. References for this definition are based on Federal Register, Vol. 45, No. 108, June 3, 1980, Part 59, Subpart A, Section 59.2 and Federal Register, Vol. 61, No. 43, March 4, 1996, Annual Update of the HHS Poverty Guidelines, Definitions, Paragraph (c).

Income is defined as total annual gross income available to support a household. The only exception to using gross income is using net income for farm and other types of self-employment. Income shall include **but** is not limited to: wages, salary, commissions, unemployment or workmen's compensation, public assistance money payments, alimony and child support payments, college and university scholarships, grants, fellowships and assistantships, etc. Income shall not include tax refunds, one-time insurance payments, gifts, loans and federal non-cash programs such as Medicare, Medicaid, food stamps, etc.

Income calculations for minors

Income for minors who request **confidential** family planning services must be calculated solely on that minor's resources (i.e., wages from part-time employment, stipends and allowances, etc.). Those services normally provided by parents/guardians (i.e., food, shelter, etc.) should not be included in determining a minor's income.

Under certain circumstances **where confidentiality is restricted** to limited members of the family, e.g., one parent is aware of the minor seeking services but the other parent is not because of disagreement regarding the minor's right to receive family planning services, the charges shall be based on the minor's income if the minor's confidentiality would be breached in seeking the full charge.

Reference: <http://www.hhs.gov/opa/pdfs/opa-97-01.pdf>

INSERT ORGANIZATION NAME OR LOGO HERE

Title X Training Log

Place in personnel file upon completion.

Name: _____ Title: _____

Date: _____

Complete ✓	Topic/Training/Presentation	Date Completed
INITIAL TRAINING AND ORIENTATION		
<input type="checkbox"/>	Title X Training (Initial Orientation)	
<input type="checkbox"/>	QFP Training (Initial Orientation)	
<input type="checkbox"/>	Cultural Competency (Initial Orientation)	
<input type="checkbox"/>		
<input type="checkbox"/>	Add agency-specific trainings here	
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
ONCE DURING EMPLOYMENT		
<input type="checkbox"/>	Non-Discrimination Policy	
<input type="checkbox"/>	Counseling Recommendations for Pregnancy	
<input type="checkbox"/>	Emergency Preparedness	
<input type="checkbox"/>		
<input type="checkbox"/>	Add agency-specific trainings here	
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
REQUIRED TRAINING PER PROJECT PERIOD (Every 3 Years)		
<input type="checkbox"/>	Voluntary Participation Policy	
<input type="checkbox"/>	No Prerequisite to Eligibility for Services Policy	
<input type="checkbox"/>	No Coercion Policy	
<input type="checkbox"/>	Child Abuse and Reporting	
<input type="checkbox"/>	Human Trafficking	
<input type="checkbox"/>	Confidentiality	
<input type="checkbox"/>	Required Adolescent Counseling	
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>	Add agency-specific trainings here	
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

****THIS LIST IS NOT EXHAUSTIVE. PLEASE UTILIZE POLICIES TO COMPLETE****

Title X Training Requirements

Frequency	Topic
Minimum during initial orientation	<p><u>Title X Family Planning Training and Orientation.</u> Staff training for key requirements of the Title X program and priority areas. (42 CFR 59.5 (b) (4)).</p> <ul style="list-style-type: none"> • Kansas Train course #1058691 • Family Planning National Training Centers: <i>Family Planning Basics</i> (http://fpntc.org/training-and-resources/family-planning-basics)
Minimum during initial orientation	<p><u>Quality Family Planning (QFP) Services.</u> Documentation that clinical staff has participated in training on QFP <i>Putting QFP into Practice Series</i> (http://fpntc.org/training-and-resources/putting-the-qfp-into-practice-series)</p>
Minimum once during employment	<p><u>Cultural Competence.</u> (KS Train course #1059262) Project staff should receive training in providing culturally competent care to the meet the unique cultural needs of the population they serve (e.g., individuals with LEP, disabled, adolescents, etc.) (42 CFR 59.5 (b) (10)).</p>
Once during employment	<p><u>Non-Discrimination Policy.</u> Staff informed at least once during employment that services must be provided without regard to religion, race, color, national origin, disability, age, and sex, number of pregnancies or marital status. (42 CFR 59.5 (a) (4)).</p>
Once during employment	<p><u>Counseling Recommendations for Pregnancy.</u> Staff has received training on pregnancy counseling recommendations presented in the QFP at least once during employment. <i>Putting QFP into Practice Series</i> (http://fpntc.org/training-and-resources/putting-the-qfp-into-practice-series)</p>
Once during employment	<p><u>Emergency Preparedness.</u> Staff has completed training and knows the1) emergency evacuation routes, and 2) understands their role in an emergency or natural disaster following the clinical facilities' emergency management plan. (29 CFR 1910, subpart E)</p>
Once each project period	<p><u>Voluntary Participation.</u> Sub-recipient staff has received training at least once during the current project period services must be provided on a voluntary basis(Sections 1001 and 1007, PHS Act; 42 CFR 59.5 (a) (2))</p>
Once each project period	<p><u>No Prerequisite to Eligibility for Services.</u> Sub-recipient staff has received training at least once during the current project period that a client's receipt of Family Planning services may not be used as a prerequisite to receipt of any other services offered by the service site. (Sections 1007 PHS Act; 42 CFR 59.5 (a)(2))</p>
Once each project period	<p><u>No Coercion.</u> Sub-recipient staff has received training at least once during the current project period staff may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure or use any particular type of contraception. (Section 205. Public Law 94-63 and 42 CFR 59.5 (a) (2) footnote 1).</p>

Title X Training Requirements

<p style="text-align: center; color: red;">Once each project period</p>	<p><u>Human Trafficking.</u> Sub-recipient staff has received training at least once during the current project period of the Federal/State requirements for reporting or notification of human trafficking. KDHE: Bureau of Family Health – Human Trafficking (KS Train Course #1037505) Human Trafficking in Healthcare – (KS Train course # 1054003)</p>
<p style="text-align: center; color: red;">Once each project period</p>	<p><u>Child and Sexual Abuse Reporting.</u> Sub-recipient staff has received training at least once during the current project period of the Federal/State requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape, or incest. See book, A Guide to Reporting Child Abuse and Neglect in Kansas. Also available at: http://www.dcf.ks.gov/services/PPS/Documents/GuidetoReportingAbuseandNeglect.pdf</p>
<p style="text-align: center; color: red;">Once each project period</p>	<p><u>Confidentiality and Privacy.</u> Staff informed at least once during current project period about policies related to preserving client confidentiality and privacy (Kansas Train Course #1028467) (42 CFR 59.11)</p>
<p style="text-align: center; color: red;">Once each project period</p> <p>(See page 64 of Federal program review tool 2016)</p>	<p><u>Required Adolescent Counseling</u> Staff received training at least once during the current project period:</p> <ul style="list-style-type: none"> • All clients under the age of 18 will be encouraged to talk with their parents/guardian or a trusted adult about their decision to seek family planning services. Resources should be provided to parents and guardians to assist them in these discussions. (Family Involvement) • Regarding resisting coercive sexual activity, sexual violence and human trafficking. • State law must be followed requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape or incest. <p>E-learning course through Family Planning National Training Centers: http://fpntc.org/training-and-resources/counseling-adolescents-about-sexual-coercion-and-abuse-0</p>

FAMILY PLANNING NEW STAFF ORIENTATION POLICY AND PROCEDURES FOR CLINICAL STAFF

1. NEW CLINICAL STAFF ORIENTATION POLICY

All delegate /subcontract agencies must provide new clinical staff (“Staff”) with adequate orientation prior to assuming responsibilities in providing care. The orientation process serves to introduce the staff to the facility, the organization and the Family Planning Program. Staff will become aware of the philosophy, policies, procedures and objective of the organization and the Family Planning Program. Staff orientation will depend upon each staff member’s needs.

New staff will receive mentoring from a qualified staff member and prior to functioning independently will meet with supervisory staff and mentor to evaluate the orientation experience and to identify further learning needs and experiences.

2. NEW CLINICAL STAFF ORIENTATION PROCEDURE

- a. Staff must review and become familiar with the following materials
 - 1) Agency Policy and Procedure Manuals including but limited to the Family Planning (FP) Program
 - 2) Doctor’s Standing Orders
 - 3) Agency’s job description for Clinical Staff position
 - 4) Agency’s Liability Policy
 - 5) The current Family Planning and Reproductive Health Manual (FPRH)
 - a) General Information Section: Introduction and Local Agency Management
Staff **must** read the Administrative and Clinical Protocol Sections of the FPRH Manual.
- b. Staff must complete required Title X Training
 - 1) Mandatory Reporting of Child Abuse and Neglect for all Mandatory Reporters
 - a) A Guide to Reporting Child Abuse & Neglect in Kansas
 - b) K.S.A 38-2223 Reporting Child Abuse and Neglect
 - a) Webinar Recording: Human Trafficking in the Family Planning Setting
 - b) KDHE: Bureau of Family Health – Human Trafficking (KS Train Course #1037505)
 - c) Human Trafficking in Healthcare – (KS Train course # 1054003) (Human Trafficking training can be accessed by various methods including webinar, teleconferences, etc.)
- c. Medical Records
 - 1) Review all current FP Chart Forms and purpose for each form
 - 2) Become familiar with required contents of FP client’s medical record
 - 3) Review agency policy and procedure on correct documentation as it relates to FP medical records
 - 4) Take part in a random medical record audit
- d. Staff will understand their role as related to common Family Planning Visits as provided in the Clinical Protocol Manual.
 - 1) Initial/Annual Exam
 - 2) Other Medical Provider Visits
 - 3) Nurse Visit
 - a) Adolescent Services
 - b) Postpartum Visit
 - c) Post-Abortion Visit

- d) Problem Visit
 - e) Deferred Physical Examination for Hormonal Contraception
 - f) Combination Hormonal Contraceptive Refill Visit
 - g) Intrauterine Contraception Device Check Visit
 - h) Pregnancy Test Visit
 - i) Male Family Planning Visit
- e. Become familiar with laboratory Procedures, Documentation, and Patient Follow-up / Contact
- f. Become familiar with agency equipment
- 1) Clinical Equipment
 - 2) Communications
 - 3) Electronic Health Record
- g. Become familiar with Pharmacy Policy and Procedure
- h. Become familiar with management of client referred for care beyond the agency's scope of practice
- 1) Agency's policy on how and number of time to attempt to contact client
 - 2) When is a client determined to be lost to follow-up
 - 3) Counseling the client on the reason and importance of follow-up
 - 4) Assisting client to identify potential resource for follow-up
 - 5) Agency's policy on transferring medical records for continuation of medical care
- i. Data Management
- 1) Know what and how to collect the minimum data elements need to meet federal reporting requirements
 - 2) Know how agency reports these element to grantee and the role of the nurse in this reporting process
- j. Financial Management
- 1) Review Agency's Financial Policy
 - a) Schedule of Fees And Discounts
 - b) Process of determining and documentation of client's income including self-declaration of income
 - c) Process of determining client's level of discount
 - d) Determine role in asking for fees and donations
 - 2) Know agency's Policy and Procedure for transferring documentations of client's fee for services and supplies between clinical and financial.
 - 3) Review documentation of services and supplies as relates to billing and coding
- k. Quality Assurance
- 1) Become familiar with Agency's Quality Assurance Policy and Procedure
 - 2) Chart audits for both clinical and administrative records / documents
 - 3) Develop corrective measures as need to improve records / documents
 - 4) Management of tracking system for following clients referred to outside agency for follow-up

FAMILY PLANNING NEW STAFF ORIENTATION POLICY AND PROCEDURES FOR NON-CLINICAL STAFF

1. NEW NON-CLINICAL STAFF ORIENTATION POLICY

All delegate/subcontract agencies must provide new staff with adequate orientation prior to assuming their responsibilities. The orientation process serves to introduce the staff to the facility, the organization and the Title X Family Planning Program. Staff will become aware of the philosophy, policies, procedures and objectives of the organization and the Family Planning Program. The staff orientation process will depend upon each staff's individual needs.

New staff should receive mentoring from a qualified staff member and prior to functioning independently will meet with supervisory staff and mentor to evaluate the orientation experience and to identify further learning needs and experiences.

2. NEW STAFF ORIENTATION PROCEDURE

- a. Staff should review and become familiar with the following materials
 - 1) Program Requirements for Title X Funded Family Planning Projects:
 - 2) Local Agency Policy and Procedure Manuals including but not limited to the Family Planning (FP) Program
 - 3) The current KDHE Family Planning and Reproductive Health Manual (FPRH)
- b. Staff must complete mandatory and required Title X Training (See "Checklist for Title X Training Requirements" in Appendix). All staff should maintain documentation of completed training
- c. Staff should be familiar with contents of Medical Records
 - 1) Review all current FP Chart Forms and the purpose for each form
 - 2) Review agency policy and procedure on documentation as it relates to FP medical records
- d. Staff should understand their role during Family Planning Visits as relates to:
 - 1) Non-discrimination
 - 2) Confidentiality
 - 3) Voluntary participation
 - 4) Conflict of Interest
 - 5) Prohibition against abortion as a method of family planning
 - 6) Clients not denied services or be subjected to any variation in quality of services because of the inability to pay
 - 7) Awareness that staff may be subject to federal prosecution if they coerce or endeavor to coerce any person to undergo abortion or sterilization procedures.
 - 8) Familiarization with range of Family Planning Services offered in local clinic
 - 9) Local Clinic flow procedures
- e. Staff should review Data Collection and Reporting policies:
 - 1) Know what and how to collect the minimum data elements needed to meet federal reporting requirements
 - 2) Know how the agency reports these elements to grantee and the role of staff in this reporting process
 - 3) Become familiar with Family Planning service Form or its equivalent in the local clinic
 - 4) Become familiar with Client Satisfaction Survey cards and how to use them.

- f. Staff should review Agency's Financial Policy related to:
 - 1) Schedule of Fees and Discounts for Family Planning clients
 - 2) The process of determining and documenting client's income including self-declaration of income
 - 3) The process of determining and documenting income for minors
 - 4) The process of determining client's level of discount
 - 5) The process of asking for donations and the payment of client fees.
 - 6) Agency collection policies
 - 7) Review policies that relate to billing and coding of Family Planning client services to third-party payers.
 - a) Confidentiality
 - b) Co-payments

- g. Staff should review Emergency Management Policies--Related to: fire, tornado, bomb-threat, terrorism, etc.
 - 1) Be able to identify emergency evacuation routes
 - 2) Understand their role in an emergency or natural disaster

- h. Staff should understand Limited English Proficiency (LEP) requirements
 - 1) Who Is a Limited English Proficient Individual?
 - 2) Oral Language Services (Interpretation) available in clinic

Resources:

Family Planning National Training Centers: *Family Planning Basics* (<http://fpntc.org/training-and-resources/family-planning-basics>)

Putting QFP into Practice Series (<http://fpntc.org/training-and-resources/putting-the-qfp-into-practice-series>)

Family Planning National Training Centers: *Counseling Adolescents About Sexual Coercion and Abuse*. <http://fpntc.org/training-and-resources/counseling-adolescents-about-sexual-coercion-and-abuse-0>

Cultural competency (KS Train course #1059262)

Confidentiality and HIPPA (Kansas Train Course #1028467)

KDHE: Bureau of Family Health – Human Trafficking (KS Train Course #1037505)

Human Trafficking in Healthcare – (KS Train course # 1054003)

Records Retention for Family Planning Title X Grant Sub Recipients

Sub-recipients generally must retain financial and programmatic records, supporting documents, statistical records and all other records considered pertinent to a grant for a period of 3 years from the submission date of the Quarter 4 (Final) Fiscal Report pertaining to the Family Planning Aid-to-Local Grant for a given State Fiscal Year.

Kansas Public Health Statutes and Regulations

Kansas Public Health Statutes and Regulations Book

The Kansas Public Health Association has available the Kansas Public Health Statutes and Regulations Book to assist those who work in public health with compilation of statutes and regulations that pertain to public health practice. For more information, go to:

http://www.kpha.us/Resources/statutes_regs_book/KPHA_SRbook_040911.pdf

Medical Records Management for Public Health

Public Health Resource Manual

This document is from the Bureau of Community Health Systems and contains important information for nurses and other professionals working in public health. There are sections pertinent to a comprehensive public health program, including Medical Records Management:

www.kdheks.gov/olrh/download/PHNResourceGuidebook.pdf.

Records Retention

Records Retention in Government

Locate policies, programs and information for records retention and historic preservation at the Kansas Historical Society. Records management for State, local and municipal government agencies can be found at:

www.kshs.org/government/index.htm.

SERIES ID	0001-111
TITLE	Client Records
DESCRIPTION	Medical records, including laboratory reports, of persons treated in local health care facilities. Includes adult and child health, family planning, maternal health, mental health and primary care.
RETENTION	See Comments
COMMENTS	Retain 10 years after last contact, and then destroy. (For juvenile records, retain 10 years after last contact or until 21st birthday, whichever is later, then destroy.)
DISPOSITION	Destroy
RESTRICTIONS	K.S.A. 45-221(a)(3)
APPROVED	2008-07-17
K.A.R. NUMBER	53-2-156