U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

POLICY INFORMATION NOTICE

DOCUMENT NUMBER: DRAFT FOR COMMENT

DATE: July 9, 2012

DOCUMENT NAME: Clarification of Sliding Fee Discount Program Requirements

TO: Health Center Program Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

The Health Center Program, authorized in section 330 of the Public Health Service Act, as amended, provides grants to support primary health care services to medically underserved communities and vulnerable populations. A requirement of the Health Center Program is for a health center to establish a "sliding fee discount program" that includes a schedule of discounts for services, or "sliding fee discount schedule," that ensures financial barriers to care are minimized for patients who meet certain eligibility criteria. All section 330-funded health centers and Federally Qualified Health Center Look-Alikes must utilize a sliding fee discount schedule that provides discounts to eligible patients based on their family size and income. This Policy Information Notice (PIN) provides clarification on the sliding fee discount program and related requirements. HRSA/BPHC is making a draft of this PIN available for comment.

When providing comments, please be as specific as possible, and reference the section of the PIN and/or page number(s). Comments will be reviewed and analyzed, and a final PIN, along with a summary and general response to comments, will be published as soon as possible after the comment submission deadline. Comments should be submitted to OPPDSFPIN@hrsa.gov by close of business **September 28, 2012**.

If you have any questions or require further guidance, please contact the Bureau of Primary Health Care, Office of Policy and Program Development, at OPPDSFPIN@hrsa.gov.

James Macrae
Associate Administrator

Attachment

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I. Purpose

The purpose of this Policy Information Notice (PIN) is to provide clarification on Health Center Program sliding fee discount program requirements including: (1) a schedule of fees for services; (2) a corresponding schedule of discounts for eligible patients that is adjusted on the basis of the patient's ability to pay (referred to as the sliding fee discount schedule (SFDS) for the purposes of this PIN)[1]; and (3) governing board-approved policies and procedures, including those around billing, collections, and waivers or reductions of any fees or payment required by the center for services that support the fee and discount schedules based on an individual's ability to pay.

II. Applicability

This PIN applies to **all** health centers funded under the Health Center Program authorized in section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended including subawardees also referred to as subrecipients. In a subrecipient[2] relationship, each organization (grantee and subrecipient) must be in compliance with all applicable section 330 requirements. The PIN also applies to Federally Qualified Health Center (FQHC) Look-Alikes. FQHC Look-Alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive the FQHC Look-Alike designation and benefits, FQHC Look-Alikes must meet the statutory, regulatory, and policy requirements for health centers programs under section 330.[3] For the purposes of this document, the term "health center" refers to health centers that are supported under section 330 of the PHS Act as well as FQHC Look-Alikes.

This PIN is the primary HRSA policy resource on the Health Center Program requirements related to a sliding fee discount program. Therefore, this PIN supersedes all other previous Health Center Program guidance and policy issued on this program requirement. Please note, however, that this policy does not supersede patient billing requirements resulting from a health center's Federally Qualified Health Center status under Titles XVIII and XIX of the Social Security Act (i.e., the Medicare and Medicaid programs), its implementing regulations, or policies.

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[1] This corresponding schedule of discounts is also commonly referred to as the "Sliding Fee Scale." "Sliding Fee Scale" has also been used as a term for the entire sliding fee discount schedule (SFDS). For the purposes of this PIN, the corresponding schedule of discounts will be referred to as the SFDS, and the entire program will separately be referred to as the sliding fee discount program.

[2] A subrecipient is an organization that "(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act . . ." (§1861(aa)(4) and §1905(l)(2)(B) of the Social Security Act). The subrecipient arrangement must be documented through a formal written contract/agreement (Section 330(a)(1) of the PHS Act).

[3] 42 U.S.C. 1395x and 42 U.S.C. 1396d.

III. Background

The Health Center Program statute requires health centers "assure that no patient will be denied health care services due to an individual's inability to pay for such services; and… assure that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill the assurance…"[4] The Health Center Program statute also requires health centers to prepare a "a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation,"[5] and "to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules; and (II) to collect reimbursement for health services to persons [covered by public or private insurance]…."[6]

In order to comply with these requirements, health centers must utilize a sliding fee discount program. Subject to the parameters provided in statute and regulation, each health center and its governing board has a degree of flexibility in designing its own sliding fee discount program. However, all sliding fee discount programs must be comprised of the following: (1) a schedule of fees for services; (2) a corresponding schedule of discounts for eligible patients that is adjusted on the basis of the patient's ability to pay; and (3) governing board-approved policies and procedures, including those around billing, collections, and waivers or reductions of any fees or payments required by the center for services that support the fee and discount schedules based on an individual's ability to pay.

Establishing a sliding fee discount program that meets program requirements allows individuals and families who are uninsured or underinsured to receive services for a fee that is adjusted based on their ability to pay and assures that equitable charges for services are applied across **all** health center patients. It also provides a mechanism for demonstrating how Federal grant funds are used to minimize financial barriers to care. Lastly, while the sliding fee discount program supports the requirement that patients share in the cost of services based on their ability to pay, no aspect of the sliding fee discount program, including the fees themselves, the procedures for assessing patient eligibility, or the procedures for collecting payment, should create additional barriers to care.

IV. General Requirements

Health centers must have a system in place to determine eligibility for and application of a sliding fee discount program. Statute and regulations state the following:[7]

1. Health centers must prepare a schedule of fees or payments for the provision of services that is consistent with locally prevailing rates or charges; and is designed to cover the

[4] 42 U.S.C. § 254b(k)(3)(G)(iii).
[5] 42 U.S.C. § 254b(k)(3)(G)(i).
[6] 42 U.S.C. §254b(k)(3)(F) and (G), 42 C.F.R. 51c.303(g) and 56.303(g).
[7] 42 U.S.C. §254b(k)(3)(F) and (G); 42 C.F.R. 51c.303(f) and 51c.303(g); 42 C.F.R. 56.303(f) and 56.303(g).

reasonable costs of operations for services included in the approved-scope of project[8]. (See Section V, Fee Schedule.)

2. Health centers must make every reasonable effort to obtain reimbursement from third party payors, including either public health insurance (Medicaid, Children's Health Insurance Program (CHIP), Medicare, and any other public assistance program) or private health insurance (for patients who have such coverage).[9] These third party payors must be billed based on the full amount of fees for such services as negotiated through their contracts without application of any discount.[10] (See Sections VI.D, Sliding Fee Discount Schedule: Co-Payments for Patients at or Below 200 Percent of the Federal Poverty Guidelines with Third Party Coverage and VII.A, Billing and Collections: Third Party Payors.)

3. For patients without coverage from third party payors (uninsured or underinsured[11]), health centers must prepare and apply a SFDS in which fees for services are adjusted based on the patient's ability to pay. (See Section VI, Sliding Fee Discount Schedule.) All SFDSs must include the following elements:

    - Applicability to all individuals and families with annual incomes at or below 200 percent of the Federal Poverty Guidelines (FPG)[12].
    - Full discount for individuals and families with annual incomes at or below 100 percent of the FPG, or allowance for a nominal charge[13] only, consistent with health center policy. (See Section VI.C, Sliding Fee Discount Schedule: Establishing and Collecting Nominal Charges.)
    - Adjustment of fees (partial discount) based on family size and income for individuals and families with incomes above 100 and at or below 200 percent of the FPG.
    - No discounts for individuals and families with annual incomes above 200 percent of the FPG.

[8] For further information on scope of project, see "Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes" available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

[9] 42 U.S.C. §254b(k)(3)(F) and (G), 42 C.F.R. 51c.303(g) and 56.303(g).

[10] 42 U.S.C. §254b(k)(3)(G)(ii)(II).

[11] See Section VI.D: Sliding Fee Discount Schedule: Co-Payments for Patients at or Below 200 Percent of the Federal Poverty Guidelines with Third Party Coverage, for applying the sliding fee discount schedule to patients with third party coverage, as applicable.

[12] The FPG are a version of the income thresholds used by the U.S. Census Bureau to estimate the number of people living in poverty. The thresholds are annual income levels below which a person or family is considered to be living in poverty. The income threshold increases by a constant amount for each additional family member.

[13] Referred to as "nominal fees" in 42 C.F.R. 51c.303(f) and 56.303(f). For the purposes of this PIN, "nominal fees" will be referred to as "nominal charges" in order to more clearly differentiate this requirement from the fee schedule.

Accordingly, health centers must charge full fees for services provided to uninsured and underinsured patients with annual incomes above 200 percent of the FPG (*no discount relative to the fee schedule*), while they must charge discounted fees for services to uninsured and underinsured patients with annual incomes above 100 and at or below 200 percent of the FPG (*partial discount*). Although health centers are not expected to charge a fee for services to uninsured and underinsured patients with incomes at or below 100 percent of the FPG (*full discount*), they may collect nominal charges (also referred to as nominal fees or nominal payments) from these patients.[14]

Every service within a health center's approved scope of project for which the health center charges patients, regardless of the service type or mode of service delivery, must be offered on a SFDS and be made available to all patients regardless of ability to pay.[15] (See Section V.A, Fee Schedule: Services.) In order to facilitate patient access and utilization, health centers must ensure that patients are aware of the sliding fee discount program and offer related information in appropriate languages and at appropriate literacy levels for patients. Specifically, health centers must establish multiple methods for informing patients of the sliding fee discount program, such as posting notice of availability of the sliding fee discount program in prominent and accessible locations at health center sites, including information in "new patient" packets, making patients aware of the discount option as a routine part of their visits during the intake and registration processes, etc.

All aspects of a health center's sliding fee discount program must be supported by written policies and implementing procedures that have been approved by its governing board. As such, these policies and procedures should be crafted to appropriately reflect the unique characteristics of the target population being served by the health center. The following areas should be addressed in these policies and procedures:

- Specific structure of the SFDS itself
- Patient eligibility for the SFDS, including temporary eligibility as applicable
- Documentation requirements to determine patient eligibility for the SFDS, including policies on self-declaration
- Collection of nominal charges
- Billing and collections, including policies applicable to refusal to pay
- Applicability of SFDS relative to deductibles, co-insurance, and/or co-payments
- Applicability of SFDS relative to supplies, equipment or other patient costs associated with services covered by the SFDS
- Use of multiple SFDSs, if applicable, with appropriate justification(s)
- Provisions for waiving fee(s) including allowing grace periods, if applicable, and staff designated with this authority

[14] 42 C.F.R. 51c.303(f) and 56.303(f).

[15] 42 U.S.C. § 254b(k)(3)(G).

Regular evaluation of these policies and procedures assures their continued alignment with the statutory intent of reducing barriers to care, their suitability for the health center and its community, and their effective implementation from both the staff and patient perspectives. As the SFDS must be revised annually to reflect updates to the FPG; ideally, the policies of the sliding fee discount program should also be evaluated at least annually and updated, as needed, to address any adverse findings relative to patient access. Health centers should routinely provide for appropriate and timely training of staff on implementation of SFDS policies and procedures.

V. Fee Schedule

The fee schedule is intended to generate revenue to cover the health center's costs of providing services, assuring the financial viability and sustainability of the health center. At a minimum, health centers must assure that fees are set to cover the health center's reasonable costs associated with providing the service and are consistent with locally prevailing rates or charges for the service.

A. Services

The first step in establishing the fee schedule is to establish the schedule of services that will have a distinct fee. This schedule should address all in-scope clinical services (required and additional) and be used as the basis for third party reimbursement. This schedule can also include non-clinical services, such as enabling services, as long as they are typically reimbursed within the local health care market.

B. Reasonable Costs

In order to establish a fee schedule, a health center must determine its actual costs for providing both its required and additional services to patients. Knowing actual costs enables the health center to accurately manage operations within their budget. Determination of a health center's actual costs requires complex analyses that are not examined within this PIN. However, for technical assistance, health centers may wish to contact their financial auditor, Primary Care Association, and/or National Cooperative Agreement organizations for additional guidance.

C. Locally Prevailing Charges

Having determined its costs of providing services, the health center must also consider "locally prevailing charges" for these services. This involves researching, reviewing and determining charges used by other health care providers in the community for the same or similar services. This information may be available from a number of sources, such as Medicare, private providers, or commercial sources. It is recommended that comparisons be made referencing commonly used service definitions, which will help both staff and patients understand the fee schedule.

As health centers conduct research in this area, please note that many private providers' charges may not be suitable comparisons because they are not based on the same comprehensive range of services that health centers provide. New health centers may rely more heavily on locally prevailing charges for constructing a cost-based fee schedule until they determine their own actual costs of operations. In any case, health centers should regularly review and adjust their charges based on analyses of their costs, productivity, and the local health care market.

VI. Sliding Fee Discount Schedule

Once a health center has established its fee schedule, it must establish a corresponding SFDS based on a patient's ability to pay. The requirements for the SFDS are established through a combination of statutory and regulatory requirements (see Section IV, General Requirements) in addition to specific individual health center governing board-approved policy. The SFDS is established and implemented as a means for ensuring that unbiased, uniform, and reasonable fees and discounts, as applicable, are consistently and evenly applied to all health center patients. Health centers are reminded that while their fee schedules are designed to cover reasonable costs for providing services, the primary purpose of the SFDS is to address financial barriers to care. Therefore, the SFDS enables the provision of services to individuals consistent with their ability to pay for such services.

Eligibility for the SFDS is based on a patient's annual income and family size under the U.S. Department of Health and Human Services' (HHS) annual FPG. To be eligible for a sliding fee discount, a patient should provide evidence of household income that does not exceed double the annual FPG, which is adjusted based on the size of the family and/or the number of people that live in the household. All decisions regarding establishing and implementing the SFDS should be based on governing board-approved policy and be monitored for effectiveness in minimizing barriers to care. Once established, the SFDS must be revised annually to reflect annual updates to the FPG.[16]

Health Center Program regulations cite "individuals and families" for the determination of eligibility for fee discounts based on income. As there is no single administrative definition of family, family unit, household, or income in the Health Center Program, the health center's governing board must determine in policy its definitions of "family" and "income" as well as the documentation it requires from patients for verification. Health centers may consider accessing or adapting definitions from other sources for their use.[17] However, the unique characteristics of

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[16] The guidelines are generally updated annually to account for increases in the Consumer Price Index. They are published in the Federal Register usually by early February of each calendar year. They are also available on the HHS poverty guidelines website at http://aspe.hhs.gov/poverty/.

[17] For example, definitions of family, household, and family unit were included in the 2003 annual update of the FPG (http://aspe.hhs.gov/POVERTY/03fedreg.htm) and may be useful to health centers in establishing their own definitions. Also, the Census Bureau uses a standard definition of income for computing poverty statistics based on

target populations and service areas should always be considered in developing individual health center policies regarding definitions and verification of family or household size and income. Once established, these policies must be applied uniformly across the patient population.

A. Determining Eligibility for Sliding Fee Discounts

The health center must evaluate a patient's eligibility for insurance and/or related third party coverage and assist the patient with applying for such coverage, as appropriate, prior to determining a patient's eligibility for the sliding fee discount. Patients who are currently not covered by third party payors for health center services at the time of their health center visit, and who meet the income guidelines based on implementation of health center sliding fee discount program policies and procedures are eligible to receive a sliding fee discount. Health center patients who are underinsured for health center services may also be eligible. (See Section VI.D. Sliding Fee Discount Schedule: Co-Payments for Patients at or Below 200 Percent of the Federal Poverty Guidelines with Third Party Coverage.) Eligibility determination procedures should be documented and periodically reviewed for compliance with established policies. It is important that the eligibility determination process be conducted in an efficient, respectful and culturally appropriate manner to assure that administrative procedures for such determinations do not themselves present a barrier to care and that patient privacy and confidentiality are protected throughout the process.

Patient eligibility for the SFDS must be determined based on the governing board approved policies. Governing board approved policies on determining eligibility must at a minimum, define family/household; define what is included (or excluded) as income; specify documentation or verification requirements for determining and recording family size and income; and establish the frequency for re-evaluation of patient eligibility. Health centers serving populations with unique characteristics should have eligibility and documentation requirements appropriate for their target population. Since health centers must adjust the SFDS based on annual updates to the FPG, patient eligibility for the SFDS should also be renewed/reviewed at least once a year.

In addition, these board approved policies should include a full description of accommodations for defined circumstances and should establish a system for ensuring that these policies and procedures can and will be uniformly applied to **all** patients. Examples of defined circumstances under which accommodations may be made include the following: ***grace periods*** may be offered to patients in order to provide an opportunity to obtain the required documentation of income and family size; income ***self-declaration*** or ***self-reporting*** may be allowed in granting eligibility to patients whose income documentation does not exist or where no reasonable option for providing it

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the poverty thresholds (http://www.census.gov/hhes/www/poverty/povdef.html) that may be used by health centers.

exists; ***emergency fee discounts/waivers*** on a case-by-case basis for patients experiencing emergency situations in which the fees normally associated with their sliding fee discount category create a barrier to care; and ***temporary eligibility*** may be granted to patients affected by insurance coverage waiting periods (e.g., they have applied for but are awaiting coverage by public or private health insurance) whereby they are considered uninsured for the purposes of qualifying for discounts. Policies related to temporary eligibility should also address the limits of such eligibility, including the method by which patients are informed of how or if they may continue to qualify for discounts.

B. SLIDING FEE DISCOUNT CATEGORIES

Health centers are required to apply a discount to the fees charged in accordance with its SFDS policies to uninsured or underinsured individuals and families with annual incomes above 100 and at or below 200 percent of the FPG. As a noted previously, uninsured and underinsured individuals and families with annual incomes at or below 100 percent of the FPG must receive a full discount for services, or pay a nominal charge only, consistent with health center policy. (See Section VI. C: Sliding Fee Discount Schedule: Establishing and Collecting Nominal Charges.) All health centers, including those that serve a large proportion of patients with incomes at or below 100% FPG (e.g., health centers targeting special populations such as people experiencing homelessness) must have board-approved policy(ies) that assure the SFDS will be applied uniformly to **all** patients who qualify.

1. Patients with Incomes above 100 and at or below 200 Percent of the Federal Poverty Guidelines

Each health center has discretion regarding how it structures the SFDS including the number of discount pay classes (incremental income categories) as well as the types of discounts (percentage of fee or fixed fee) offered to patients above 100 and at or below 200 percent of the FPG. A SFDS with at least three (3) and no more than five (5) discount pay classes tied to graduations in income levels (above 100 and at or below 200 percent of the FPG) is recommended for effectiveness in meeting the statutory intent and in its practical application for patients[18]. If a health center decides to establish a SFDS that is inconsistent with this recommendation, the justification for establishing such a SFDS should be documented in the board meeting minutes where it was discussed and approved. In all cases, the structure of the SFDS should be routinely evaluated to ensure that it meets the statutory intent of the Health Center Program that cost is not a barrier to care.

2. Patients with Incomes Over 200 Percent of the Federal Poverty Guidelines

[18] Health centers may also want to consider Health Center Program reporting requirements relative to patient income when constructing the SFDS. Please see most recent Uniform Data System (UDS) Reporting Manual for details.

For services provided to individuals and families with annual incomes above 200 percent of the FPG, health centers must either charge full fees and/or seek reimbursement from a third party since these patients are not eligible for discounted services. However, it is understood that health centers may receive or have access to Federal, State, local, or private funds that have different fee requirements and/or that are specifically targeted to reduce the costs of providing services to uninsured and underinsured patients including those over 200 percent of the FPG. Health centers receiving or accessing such funds must honor the terms of grantors with respect to the use of their funds. For example, a health center that also receives funding under the Ryan White Program would be allowed to use Ryan White grant funds to provide discount services to individuals eligible for Ryan White-funded services including those individuals with incomes above 200 percent of the FPG in accordance with Ryan White Program requirements for annual caps on fees.

Further, when health centers receive access to funding from other Federal, State, local, or private sources that can be considered a payor source or a subsidy, then the health center may charge the full, undiscounted fee for an eligible patient's fees to that funding source. An example would include a special State fund that supports health services to qualified individuals with incomes over 200 percent of the FPG who are working and uninsured. In this scenario, a qualifying patient's account could reflect the full fee for the service rendered (no discount consistent with a compliant SFDS), but the State fund could be charged for that fee on behalf of the patient.

C. Establishing and Collecting Nominal Charges

As required by Health Center Program regulations,[19] health centers must provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG who have no third party coverage or whose fees are not covered by third party payors (including public or private health insurance). As part of its sliding fee discount program, a health center may establish and implement nominal charges for these patients, as long as in doing so, it ensures that patients are not limited in accessing services due to an inability to pay. A nominal charge is a fixed, small fee that does not reflect the true value of a service provided and is generally considered to be of token value.

HRSA recognizes that nominal charges allow patients to participate in supporting the cost of services and may also serve to prevent inappropriate utilization of services. However, they may not be referred to as "minimum fees," "minimum charges," or "co-pays" as they are not intended to create a payment threshold for patients to receive care, nor may they be set at such a level or administered in such a way as to create a barrier to care. Further, a nominal charge should be reasonably related to a patient's ability to pay, and in no instance can it be more than the fees paid by a patient in the first "sliding fee discount category" beginning above 100 percent of the FPG.

[19] 42 C.F.R. 51c.303(f) and 56.303(f).

Whether to establish nominal charges and at what level is a policy decision that must be made by a health center's governing board. If the health center elects to establish and implement nominal charges, in determining the amount, it should consider currently established cost-sharing fees associated with other third-party payors, such as Medicare and Medicaid, for patients with comparable incomes. Related policies and procedures must include provisions for waiving the nominal charge based on established criteria that are applied to all patients equally, in order to ensure that patients are not being denied care based on their inability to pay the nominal charge.[20] Only those specific health center staff delegated with the authority to apply these policies should do so, and the policies must be applied to all patients equally. Health center staff, including an individual board member, Executive Director, provider, or other staff member, may not independently waive charges for a particular patient nor declare a particular service as free of charge. As with all health center policies and procedures on the SFDS, the amount of the nominal charge(s) should be routinely evaluated for appropriateness to ensure such fees remain consistent with the statutory intent of assuring access to care regardless of ability to pay.

D. Co-Payments for Patients At or Below 200 Percent of the Federal Poverty Guidelines with Third Party Coverage

HRSA recognizes that health centers serve underinsured individuals who have or are eligible for public or private health insurance (third party coverage) that may not cover or may only partially cover fees for certain health center services, and who also qualify for the SFDS based on income and family size. These underinsured individuals may not pay more than uninsured patients in the same income category. In addition, the SFDS is applicable to patient fees not covered by the third party payors, such as co-insurances, and/or co-payments. Federal law[21] permits health centers to waive co-payments for certain low-income Medicare and Medicaid patients without violating anti-kickback provisions. Implementing regulations can be found at 42 C.F.R. §1001.952(k)(2). Please note, however, in making health center policy decisions applicable to these situations, each health center governing board should consider the needs of its patient population as well as the financial viability of the health center. Health centers should consult with private legal counsel regarding modification of contracts with third party payors related to reducing or waiving co-payments or co-insurances set by the third party payor.

E. Multiple Sliding Fee Discount Schedules

As discussed previously, sliding fee discounts must apply to all services within a health center's approved scope of project for which the health center has established a charge, regardless of the service type (required or additional, clinical or non-clinical) or mode of delivery (directly or by contract, i.e., Form 5A, Columns I, and/or II). The discounts

[20] 42 U.S.C. §254b(k)(3)(G)(iii).

[21] 42 U.S.C. § 1320(b)(3)(D).

themselves are not required to be identical for all health center service categories (e.g., medical, dental, behavioral health) as long as access to each service category has been considered in developing the specific SFDS, that documentation exists to support that such varying SFDS do not result in additional barriers to care, and that each SFDS is uniformly applied to all patients. Each health center must include such documentation in the board meeting minutes where multiple SFDSs were discussed, and the board-approved discount policy was approved. The presence of multiple SFDSs should be routinely evaluated to ensure that they do not inadvertently create a barrier to care.

For services the health center provides via a formal written referral arrangement within the federally approved scope of project, where the actual service is provided and paid for/billed by another entity (i.e., Form 5A, Column III), the health center is responsible for assuring that the service is available to its health center patients regardless of their ability to pay and offered on a SFDS. Specifically, the health center must ensure that the written referral arrangement between the two organizations appropriately addresses the availability of SFDS. Although the SFDS implemented by the referral provider is not required to match the SFDS for services the health center provides directly, this SFDS must at a minimum apply to fees for all uninsured and underinsured health center patients at or below 200 percent of the FPG. As part of the health center's oversight of the arrangement, the referral provider's SFDS should be reviewed, approved, and continuously monitored by the health center to ensure that it assures access to care regardless of the patients' ability to pay, and is clearly communicated to patients (See Section IV, General Requirements).

F. Applicability of Sliding Fee Discount Schedules to Service-Related Supplies/Materials

Health centers may provide health services that include medically-related supplies or materials as an integral part of the provision of the service (such as a cast when setting a broken bone). Such supplies or materials are often referred to as "incident to" the provider's service.[22] In these situations, the health center must include a single bundled fee for this service that is inclusive of the associated supplies/materials and consistent with locally prevailing charges (See Section V: Fee Schedule). The SFDS must then be applied to this single bundled fee.

Health centers may also provide other supplies or materials (such as eyeglasses) that may be charged separately based on locally prevailing rate structures, as they are related, but not "incident to" or an integral part of the provision of a given service. In these situations, health centers are not specifically mandated to apply their SFDS to such

[22] These types of "incident to" supplies would be similar to those included as "incident to" Federally Qualified Health Center services for the purposes of Medicare/Medicaid reimbursement, as described in section 1861(aa)(3) of the Social Security Act. For more information on the types of supplies included in this definition, please see the Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, Section 60 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//bp102c15.pdf.

supplies/materials. However, when establishing charges for these types of supplies/materials, health centers should consider and periodically assess their impact in order to ensure that such charges do not result in a barrier to receiving related services that are within the health center's approved scope of project. Please note that patients should be made aware of any and all supplies/materials for which there will be a separate charge. Such charges should be noted on the health center's fee schedule along with a clear message regarding the applicability of the SFDS and/or any other discounts.

VII. Billing and Collections

HRSA recognizes the challenge each health center faces in balancing its mission of ensuring access to services without regard to a patient's ability to pay with its own short and long-term financial sustainability. Reimbursement for services received from public and private third party payors as well as payments from patients who are able to pay for some or all of the cost of their care provide a significant and necessary source of revenue to ensure this financial sustainability. Adequate policies and procedures are critical to the health center's ability to carry out both the sliding fee discount program requirement and the requirement for health centers to maximize revenue from public and private third party payors.

The billing and collections component of the sliding fee discount program is established through board-approved policies that include procedures for billing patients and third party payors within a reasonable period of time after services are provided, typically within 30 days. Health centers and their staff must comply with applicable Federal and State regulations as well as with the individual health center's policies and procedures regarding these activities. Health centers are also required to have a system for maintaining the confidentiality of all personal patient information and records.[23] They must protect their patients' personal and confidential or privileged financial information, and patients must be notified of these confidentiality and security practices.

A. Billing Third Party Payors

Health centers are required to maximize revenue from public and private third party payors.[24] Therefore, health centers must participate in Medicare, Medicaid, CHIP, and private and other health insurance programs used by their patient populations. Health centers must first evaluate a patient's existing coverage or eligibility for coverage under public and private third party payors before assessing their eligibility for the SFDS.

1. Public Assistance Programs

[23] 42 U.S.C. § 254b(k)(3)(C); 42 C.F.R. 51c.110,51c.303(b), 56.111, and 56.303(b).
[24] 42 U.S.C. § 254b(k)(3)(F).

Section 330 and implementing regulations require health centers to participate in Title XVIII (Medicare Program) of the Social Security Act (SSA), Title XIX of the SSA (State Medicaid Program), and Title XXI of the SSA (Children's Health Insurance Program), and any other public assistance programs that are available to its patients.[25] In addition, health centers are required to make "every reasonable effort" to collect "appropriate reimbursement for its costs" in providing health services to persons who are entitled to health benefits under such programs.[26] Further, health centers are required to collect reimbursement "on the basis of the full amount of fees and payments for such services without application of any discount."[27] However, since rates of reimbursement by public assistance programs, such as Medicare, Medicaid, and CHIP, are often set by legislation or a government administrative agency, HRSA recognizes that an individual health center's ability to negotiate reimbursement rates is often limited by these circumstances.

Health centers should bill Medicare, Medicaid, CHIP, or other public assistance programs for the services provided to beneficiaries in accordance with each program's requirements.

2. Private Health Insurance

Similarly, section 330 requires health centers to make "every reasonable effort" to collect reimbursement for services provided to persons covered by private health insurance "on the basis of the full amount of fees and payments for such services without application of any discount."[28] Health centers should bill privately-insured patients and/or submit claims to their insurance plans for the services provided according to the health center's established fee schedule. HRSA recognizes that in many cases, an individual health center's ability to negotiate reimbursement rates for services may be limited. In those cases, health centers may accept a reimbursement rate from a private health insurance plan that may be less than its established fee for a service. HRSA continues to encourage health centers to seek reimbursement for reasonable costs for providing services and reimbursement rates that are consistent with what the insurer pays other providers in the community for that service (i.e., reflects locally prevailing charges and reimbursement rates).

B. Billing Patients

Health centers are required to make reasonable efforts to secure payment from patients for services rendered based on their established SFDS and as implemented through accompanying policies in a manner that assures that no patient will be denied services

[25] 42 U.S.C. §254b(k)(3)(F) and (G), 42 C.F.R. 51c.303(g) and 56.303(g).

[26] 42 U.S.C. § 254b(k)(3)(F).

[27] 42 U.S.C. § 254b(k)(3)(G)(ii)(II).

[28] 42 U.S.C. § 254b(k)(3)(F).

based on an inability to pay.[29] As stated earlier, payments from patients who are able to pay for some or all of the cost of their care are another key source of revenue for health centers.

1. Patient Billing and Collections

Health centers' board approved billing and collection policies and procedures must be consistent with the requirements for the sliding fee discount program. In addition, health centers' governing boards must evaluate these policies and procedures periodically and update them, as needed. As with all sliding fee discount program elements, billing and collections should be conducted in an efficient, respectful and culturally appropriate manner to assure that administrative procedures do not themselves present a barrier to care and that patient privacy and confidentiality are protected throughout the process. Within these policies and procedures, health centers may consider the circumstances under which they allow alternatives to traditional billing, such as payment plans, in order to further reduce cost as a barrier to care. However, health centers must make such alternatives consistently available to all patients.

Even though it is recognized that billing requires administrative time and effort, health centers are not permitted to charge billing fees (e.g., administrative fees or collection fees above and beyond the cost of the actual service(s) that the health center provided when repeated efforts at fee recovery are necessary) to patients at or below 200 percent of the FPG. If a health center considers billing fees necessary and appropriate for patients above 200 percent of FPG, then the practice should be used only after analyzing the likelihood of receiving payment from a patient. In addition, this practice must be clearly documented in board-approved policies, communicated to patients, and used only after other efforts to collect payment from the patient have failed.

2. Payment Incentives

Incentives, often referred to as "prompt payment/ cash payment incentives," may be offered to patients who pay with cash and/or who pay their bill within a specific, expedited timeframe. Such incentives must be accessible to **all** patients, regardless of income level, and consistently applied without preferential treatment of any kind. The potential consequences of implementing cash or prompt pay incentives for patients and the health center should be thoroughly researched. If implemented, such decisions should be documented in the health center's board-approved billing and collection policy and should be clearly communicated to patients.

3. Refusal to Pay

[29] 42 U.S.C. § 254b((k)(3)(G)(ii) and (iii).

As stated above, health centers must continually balance making reasonable efforts to secure payment for services in accordance with their established SFDS and billing and collections policies, while assuring that no patient is denied services due to an inability to pay. Therefore, each health center must take steps to ensure that its determination of an individual's ability to pay is up-to-date and based on the patient's current financial status and family size, as individual patient circumstances may change frequently.

HRSA acknowledges that there may be instances when a patient refuses to pay based on the established SFDS or to allow for payment by third parties for services provided by the health center. As a result, health centers should establish board-approved policies and procedures for addressing these instances that clearly define: what constitutes "refusal to pay"; what individual circumstances are to be considered in making such determinations; and what steps are to be followed in the process (e.g., offering grace periods, establishing payment plans, utilizing collection agencies[30]).

Only after reasonable efforts have been made to secure payments and/or bill for amounts owed to the health center for services provided may health centers choose to implement policies where these patients are discharged from the regular practice. Health centers are reminded that such determinations must be made in a manner that is consistent with their established policies and procedures, which should include documenting the actions taken to secure payment from the patient. Discharging a patient from the practice due to refusal to pay should be viewed as a "last resort" when all other options have been exhausted. In addition, health centers should consider establishing related policies and procedures for determining how patients may be able to rejoin the regular practice at a future date. Health centers should seek private counsel in considering state requirements and other obligations that may arise in such cases.

VIII. Effective Date

This policy will become effective upon issuance of a final PIN. As described in PAL 2010-01 "Enhancements to Support Health Center Program Requirements Monitoring,"[31] HRSA is committed to assisting grantees to remedy identified areas of non-compliance and to providing reasonable time for grantees to take necessary corrective action through the Progressive Action process.

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[30] It should be noted that when a health center enters into a contract with an outside organization to carry out particular health center policies and procedures, the health center must ensure that program requirements continue to be met. Thus, as with any other contractual arrangement, the health center must perform a cost/benefit analysis, follow procurement policies and procedures, and maintain sufficient control and oversight over the contracted services, including monitoring their impact on the patients/community and amending the contract, as needed.

[31] Available at http://www.bphc.hrsa.gov/policiesregulations/policies/pal201001.html.

IX. Contacts

If you have any questions or require further guidance regarding the policies detailed in this PIN, please contact the Bureau of Primary Health Care, Office of Policy and Program Development at OPPDSFPIN@hrsa.gov. Health centers that have questions or concerns regarding their individual sliding fee discount program should contact their Project Officer for assistance.