Federally Qualified Health Center and Look-Alike Sliding Fee Discount and Related Billing and Collections Program Requirements

Practices Must Be Based on Written Policies that Have Been Approved and Applied Uniformly

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All federally qualified health centers and look-alikes (collectively referred to as "health centers") must utilize a sliding fee discount schedule that provides discounts to eligible patients based on their family size and income. The Health Services Resource Administration (HRSA) recently released PIN 2014-02, which provides clarification on the sliding fee discount program and related billing and collection requirements.[1] PIN 2014-02 supersedes all other previous health center program guidance and policy issued on sliding fee discount schedule requirements.

General Requirements

In addition to the regular fee schedule, health centers must have a sliding fee schedule for low-income and indigent individuals and a system in place to determine eligibility for and application of the sliding fee discount program. In particular, statute and regulations provide that:[2]

1. Health centers must prepare a schedule of fees for services that covers the reasonable costs of providing the services included in the approved scope of project and is consistent with locally prevailing rates or charges.[3]
2. Health centers must prepare and use a sliding fee discount schedule (SFDS) so that the amounts that eligible patients pay for health center services are adjusted based on the patient's ability to pay.[4] 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);[5]
- full discount for individuals and families with annual incomes at or below 100 percent of the FPG, or allowance for a nominal charge,[6] consistent with board-approved health center policy;
- partial sliding fee discount based on family size and income for individuals and families with incomes above 100 and at or below 200 percent of the FPG; and
- no sliding fee discounts for individuals and families with annual incomes above 200 percent of the FPG.

3. Health centers must make every reasonable effort to obtain reimbursement from third-party payors (*e.g.*, Medicaid, CHIP, Medicare, and any other public assistance program or private health insurance).[7]

In addition, every service within a health center's approved scope of project for which the health center has established a charge, regardless of the service type or mode of service delivery, must be made available to all health center patients regardless of ability to pay.[8]

Governing Board Oversight

Health center governing boards must approve general health center policies, including those associated with the sliding fee discount program. Day-to-day direction and management responsibility for implementing the operating procedures for the sliding fee discount program rests with health center staff under the direction of the chief executive officer or executive director. However, the board is responsible for reviewing evaluations of the sliding fee discount program and for updating policies or directing the chief executive officer (CEO), as appropriate.[9] In addition, health centers should routinely provide for staff training on implementation of sliding fee discount program policies and supporting operating procedures.

All aspects of a health center's sliding fee discount program must be based on written policies that have been approved by its governing board, applied uniformly to all patients, and further supported by operating procedures. At a minimum, the following areas must be addressed in the sliding fee discount program policies and procedures:

- patient eligibility for the SFDS, including definitions of income and family size and frequency of re-evaluation of patient eligibility;
- documentation and verification requirements to determine patient eligibility for the SFDS;
- specific structure of the SFDS itself;
- billing and collections; and
- provisions for waiving fee(s) and nominal charges for specific patient circumstances.[10]

The governing board also has discretion regarding certain optional aspects of the health center's sliding fee discount program. Those are as follows:

- alternative mechanisms for determining patient eligibility for the SFDS where documentation/verification is unavailable (*e.g.*, self-declaration, conditional SFDS eligibility) and for making these mechanisms available to the entire patient population, regardless of income level, sliding fee discount pay class, or population type;
- establishing and collecting nominal charges;
- use of multiple SFDS, if applicable, with appropriate justification(s);
- applicability of SFDS or other discounts relative to supplies and equipment associated with services covered by the SFDS; and/or
- other provisions related to billing and collections including payment incentives, grace periods, payment plans, or refusal to pay guidelines.[11]

If a health center elects to include any of these optional items, the governing board

must adopt and approve policies and supporting operating procedures for each item.

Fee Schedule

The health center must ensure that its fees cover the reasonable costs of services provided by the center and are consistent with locally prevailing rates or charges for the service. The health center's fee schedule should address all in-scope services (required and additional)[12] and should be used for payments by patients as well as third-party payors. The health center conducts regular periodic cost analyses and changes in the local health market and must adjust fees, as appropriate, based on those cost analyses, as well as changes in the local health care market.

Services

The first step in establishing the health center's fee schedule is to determine those services that will have distinct fees. Health center services, laboratory services, and/or medically related supplies and equipment may be combined into a single fee, consistent with both prevailing standards of care and locally prevailing charges.[13] Multiple visits (such as those associated with prenatal care) also may be grouped together with a single fee. The health center's fee schedule may include distinct fees for in-scope elements, such as enabling services, as long as they are typically billed and/or reimbursed separately within the local health care market.

Reasonable Costs and Locally Prevailing Charges

In order to establish the fee schedule, the health center must determine its actual costs for providing both its required and its additional (*e.g.*, optional) services to patients. Having determined its costs for providing services, the health center also must consider "locally prevailing charges" for these services.[14] 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, Medicaid, Resource-Based Relative Value Scale (RBRVS or RVUs), commercial insurance fee schedules, the FAIR Health Fee Estimator, or conducting a fee schedule cost study. If there are no other comparable health care providers in the community, health centers may make comparisons to other, similarly situated communities.

Sliding Fee Discount Schedule (SFDS)

Once the health center has established its fee schedule, it must establish a corresponding SFDS based on a patient's ability to pay. All services within the health center's approved scope of project, whether required or additional, must be provided on an SFDS and without regard to the patient's ability to pay. Once established, the SFDS must be revised annually, at a minimum, to reflect annual updates to the FPG.[15]

Determining Eligibility for Sliding Fee Discounts

Health centers must have supporting processes/operating procedures in place for assessing income and household size for all patients to assist the center and its patients in determining whether patients are eligible for sliding fee discounts.[16] It is important that the eligibility determination process be conducted in an efficient, respectful, and culturally appropriate manner to ensure that administrative operating procedures for such determinations do not themselves present a barrier to care.

Eligibility for the SFDS should be based on a patient's annual income and family size under the U.S. Department of Health and Human Services' (HHS') annual FPG. The health center's governing board must approve the health center's definitions of "family" and "income." Since the FPG does not define either what income is to be counted or whose income is to be included in the household or family, the health center has some discretion; however, income

is often defined as the gross income reported for federal income tax purposes. This includes gross wages, tips, social security disability, veteran payments, alimony, child support, military, unemployment, and public aid. Family is often defined as the head of household, the spouse, and their dependents. The definition of dependent varies but often is either tied either to the Internal Revenue Service (IRS) rules or to those individuals the applicant is legally obligated to support.

A patient's application for third-party coverage cannot be a condition for eligibility for a sliding fee scale discount or to receive services. Health centers may not deny discounted services on the basis of an individual's assets if such individuals would be eligible for the sliding fee scale discount program if they would be eligible under income guidelines. In addition, limiting an individual's access to discounts on the basis of citizenship or residency is not permitted by the laws and regulations governing health centers. Individuals and families with annual incomes above 200 percent of the FPG are not eligible for sliding fee discounts.[17]

When verifying income, the simplest approach is to accept the patient's word at the time the request is made and request the individual provide some form of verification within a certain number of days after the sliding fee discount application is completed. Verification typically should include tax returns/paycheck stubs; a signed letter from the employer stating hours worked per week or biweekly and pay per hour; for unearned income — proof of child support, social security statements, or unemployment check stubs; or if no household income — a document denying medical assistance.

If the documentation is supplied at a later date, it is important that the health center staff ensure that they followup on the application and make sure the information gets in the file with the application. In addition to annualized income verification, eligibility may be based on current participation in certain federal/state public assistance programs, examples of which include the following: Social Security income (disability); free or reduced school lunch program; temporary assistance for needy families; or other public assistance programs. All documentation and verification information should be kept on file with the application, and the application should be signed by the patient.

Once the patient has signed the application and the center has completed its assessment and verification, a patient who meets the income guidelines would receive a sliding fee discount based on the SFDS. The health center's eligibility determination process must be documented and its implementation periodically reviewed for compliance and effectiveness. The patient's eligibility term for the program is usually one year and generally must be reviewed and renewed as applicable on the anniversary date of the date the application for eligibility is approved. Eligibility terms of less than one year are permitted but rarely used and are more time consuming and costly to administer.

Sliding Fee Discount Schedule Structure

In accordance with their SFDS policies, health centers are required to apply a discount to fees charged to patients who have been determined eligible for sliding fee discounts. Individuals and families with annual incomes at or below 100 percent of the FPG must receive a full discount for services or, consistent with individual health center policy, pay only a nominal charge. All health centers, including those that serve a large proportion of patients with incomes at or below 100 percent of the FPG, must have board-approved policies and supporting operating procedures which assure that sliding fee discounts will be applied uniformly to patients who qualify for such discounts based on incomes above 100 percent and at or below 200 percent of the FPG.

In order for the SFDS to be structured in a manner that adjusts based on ability to pay, an SFDS must have at least three discount pay classes above 100 percent and at or below 200 percent of the FPG. In addition, these discount pay classes must be tied to gradations in income levels. Each health center has discretion regarding how it structures the SFDS, including the number of discount pay classes, and the types of discounts (percentage of fee or fixed/flat fee for each discount pay class) it offers. In addition to revising the SFDS annually to reflect updates to the FPG, the structure of the SFDS also should be evaluated at least annually for its effectiveness in addressing financial barriers to care and updated, as appropriate.[18]

Establishing and Collecting Nominal Charges

Health centers must provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG.[19] Program regulations permit health centers to adopt a nominal charge for services for patients at or below 100 percent of the FPG; however, electing to establish a nominal charge is at the discretion of the health center. Depending on the health center's patient population, applying a nominal charge may be an appropriate means for health center patients to invest in their care and to minimize the potential for inappropriate utilization of services.

Any health center that chooses to establish a nominal charge must ensure that patients are not impeded in accessing services due to their inability to pay. Specifically, a nominal charge must be a fixed fee that does not reflect the true value of the service(s) provided and is considered nominal from the perspective of the patient. As these nominal charges are not intended to create a payment barrier for patients to receive care, nominal charges are not "minimum fees," "minimum charges," or "co-pays." In addition, the nominal charge must be less than the fee paid by a patient in the first "sliding fee discount pay class" beginning above 100 percent of the FPG.[20]

Patients with Third-Party Coverage Who Are Also Eligible for SFDS

Health centers may serve patients with third-party insurance that does not cover or only partially covers fees for certain health center services. These patients also may be eligible for the SFDS based on income and family size. In such cases, subject to potential legal and contractual limitations,[21] the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.

Multiple Sliding Fee Discount Schedules

Sliding fee discounts must apply to all services within a health center's approved scope of project for which there is an established charge, regardless of the service type (required or additional) or mode of delivery (direct, by contract, or by formal referral agreement. Health centers may elect to have multiple SFDSs based on services/mode of delivery, but each of them must comply with PIN 2014-02, and in cases where the health center has elected to establish a nominal charge for patients at or below 100 percent of the FPG, the charge must meet the criteria for a nominal charge. In addition, patient access and uniform implementation must be taken into consideration in developing each SFDS, and the health center must have a plan for routinely evaluating each SFDS and presenting the information to the board to ensure that it does not create a barrier to care.

Referral Services

For services the health center provides solely 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, the health center must ensure the services are available to its patients regardless of their ability to pay and offered on an SFDS. This SFDS does not need to be the same as the health center's SFDS. A health center also may enter into a formal written referral arrangement that results in greater discounts to patients than they would receive under the health center's SFDS policy if such policy were applied to the referral provider's fee schedule, as long as: (a) all health center patients at or below 200 percent of the FPG receive a greater discount for these services than if the health center's SFDS was applied to the referral provider's fee schedule; and (b) patients at or below 100 percent of the FPG receive no charge or only a nominal charge for these services.[22] The sliding fee discount program requirements do not apply to services provided via informal referral arrangements, as the health center does not include such arrangements for services in its federally approved scope of project.[23]

Advertising the Sliding Fee Discount Schedule

In order to facilitate patient access and utilization, health centers must ensure that patients are made aware of the sliding fee discount program. Health centers should establish multiple methods for informing patients of the sliding fee discount program (*e.g.*, signage, registration process). For example, health centers should prominently post language onsite in the lobby and cashier's desk announcing the availability of discounts, and on their Web site (if one exists), stating that patients will not be denied services based on inability to pay and that discounts are available based on family size and income.

The sliding/discounted fee schedule should be presented as an option during a patient's initial visit. Health centers do not have to post details of the policy or the actual fee schedule. In addition, information about the sliding fee discount program should be available in appropriate languages and literacy levels for the health center's target population.[24]

Billing and Collections

Health center billing and collections policies and supporting operating procedures should address billing patients and third-party payors within a reasonable period of time after services are provided, typically within 30 days.

Billing Third-Party Payors

Health centers are required to participate in the state Medicaid and Children's Health Insurance programs[25] and are required to make "every reasonable effort" to collect "appropriate reimbursement" from the Medicare program, Medicaid, CHIP, and other public assistance programs and private third-party payors used by their patient populations.[26] Health centers must educate patients on public or private insurance options available to them based on their eligibility for insurance and/or related third-party coverage. 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]

Billing Patients

At the time of the initial patient visit, the full value of services provided to the patient should be recorded for billing purposes. If a nominal fee has been established for any service, either the discounted charge or the nominal fee, whichever is greater, should be imposed, and efforts should be made to collect this amount in accordance with the health center's established billing and collection policies and procedures. Full charges should be recorded in the health center accounting records, and an entry should be made to reflect the value of the discounted service as an adjustment against full charges.

Health centers must make reasonable efforts to collect payment from patients for services rendered, while ensuring that no patient is denied services based on inability to pay.[28] Billing and collecting from patients should be conducted in an efficient, respectful, and culturally appropriate manner, assuring that procedures do not present a barrier to care and patient privacy and confidentiality are protected throughout the process.

Provisions for Waiving Charges

Any provision for waiving charges must be consistently made available to qualified patients. Health centers must establish policies and supporting operating procedures that identify circumstances with specified criteria for waiving charges, and identify specific health center staff with the authority to approve the waiving of charges.

Payment Incentives

Health centers may elect to offer prompt payment/cash payment incentives through board-approved billing and collections policies. Such incentives provide a discount to patients who pay with cash and/or who pay their bills within a specific, expedited timeframe as a method of increasing collections and reducing billing costs. The operating procedures that support such a policy must ensure that these incentives are accessible to all patients, regardless of income level or sliding fee discount pay class, and consistently applied without preferential treatment of any kind. Health centers also should have a mechanism for communicating the availability of these incentives to all of their patients.

Refusal to Pay

Health centers may elect to establish "refusal to pay" policies but must establish supporting operating procedures that define:

- what constitutes "refusal to pay;"
- what individual circumstances are to be considered in making such determinations; and
- what collection efforts/enforcement steps are to be taken when these situations occur (*e.g.*, offering grace periods, establishing payment plans, meetings with a financial counselor).

Discharging patients due to refusal to pay should be an action of "last resort" to be taken only after reasonable efforts have been made to secure payments and/or bill for amounts owed to the health center for services provided. The health center should document all steps taken to secure payment from the patient prior to discharging. Health centers should establish related policies for determining how and when patients may be permitted to rejoin the practice at a future date.[29]

Compliance Program Implementation and Oversight

The health center sliding fee discount schedule, sliding fee discount program policy and procedure, patient applications and eligibility determinations for the sliding fee discount program, signage and Web site language that advertises the availability of the sliding fee discount program, and other related materials should be incorporated into the health center compliance program.

Policies and Procedures

Health centers are required to develop policies and supporting operating procedures that include provisions for the sliding fee scale discount schedule, waiving fees, and nominal charges for specific patient circumstances. The unique characteristics of target populations (*e.g.*, individuals experiencing homelessness) and service areas (*e.g.*, areas with high cost of living) must be considered in developing policies and supporting operating procedures to ensure that these elements do not become a barrier to care.

Training and Education

Office staff must be trained annually on the availability of the program and the policy and procedures for implementation. At all times at least one staff member working

should know how to collect the necessary documentation and determine the discount percentage.

Documentation

Billing and collections compliance program documentation should include the health center chargemaster (schedule of fees), governmental program payor provider numbers, billing and collection policies and procedures, and proof of timely billing of third-party payors. When possible, the health center's automated practice management system should support the sliding fee discount program by having it set the sliding fee class; flag expired accounts; generate mailing lists for patients whose eligibility is about to expire so applications can be mailed; and track the charges, collections, and visits by sliding fee class in order to be able to evaluate the collections experience.

Auditing and Monitoring

On a monthly or quarterly basis the health center should select a sample number of accounts and test for compliance as part of its quality improvement program. Auditors should test eligibility in various ways, including but not limited to:

1. policies and procedures specify sliding fee discount policy;
2. policies and procedures specify the current fee schedule;
3. policies and procedures specify the process for charging, obtaining, and documenting patient charges;
4. policies and procedures specify that the sliding fee discount policy and schedule do not allow patients below 100 percent of the FPG to be charged for services and ensure appropriate screening and reassessment of patients to determine SFDS eligibility;
5. billing and collections policies and procedures that do not require full payment prior to service, or deny services for non-payment;
6. document individual provider and health center provider numbers for participation in Medicaid, Medicare, and CHIP programs;
7. document that all staff involved in eligibility determination have participated in comprehensive training in eligibility determination requirements;
8. document that each patient is screened for insurance coverage and eligibility for third-party programs or SFDS;
9. document health center obtains written documentation of income and family size and conducts a recertification annually;
10. review patient files and documentation of actual charges and payments to ensure SFDS policy is being correctly and consistently enforced;
11. review system for tracking patient charges and payments; and
12. test special program recipients (*e.g.*, HIV) to ensure that participants in the program have been diagnosed with the requisite illness/eligibility.

Conclusion

All aspects of a health center's sliding fee discount program and related billing and collections practices must be based on written policies that have been approved by its governing board, applied uniformly to all patients, and further supported by operating procedures. The reasonableness of fees, and the percent of a full fee that is assessed, may be subject to review or challenge by federal reviewers during routine reviews by duly authorized federal staff or their state counterparts.

Endnotes:

1. Program Information Notice 2014-02, "Sliding Fee Discount and Related Billing and Collections Program Requirements," September 22, 2014 (PIN 2014-02). Available online at bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201402.pdf.
2. 42 U.S.C. §254b(k)(3)(F) and (G); See also 42 C.F.R. 51c.303(f) and 51c.303(g); 42 C.F.R. 56.303(f) and 56.303(g).
3. 42 U.S.C. § 254b(k)(3)(G)(i). Health centers are required to prepare "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."

4. 42 U.S.C. § 254b(k)(3)(G)(iii). Health centers are required to "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 …."
5. 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. The FPG are updated annually to account for increases in the consumer price index. The FPG can be accessed online at aspe.hhs.gov/poverty.
6. 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 underscore that there is no relationship between this charge and the term "fee" as used in "fee" schedule.
7. 42 U.S.C. §254b(k)(3)(F) and (G), 42 C.F.R. 51c.303(g) and 56.303(g).
8. 42 U.S.C. § 254b(k)(3)(G).
9. The SFDS must be revised annually to reflect updates to the FPG, and the entire sliding fee discount program also should be evaluated by the board at least annually and updated, as appropriate.
10. Note 1, supra.
11. *Id*.
12. The provision of some health center services may be associated with services/goods outside the health center's scope of project and provided by an entity other than the health center (such as a hospital). In such cases, the health center should inform patients that they may be billed for the services/goods by another entity in accordance with the other entity's policies and procedures.
13. Health centers may acquire/purchase and/or facilitate access to supplies and equipment that are related to but not included in the services as part of prevailing standards of care.
14. HRSA cannot approve a health center unless the health center: "Has prepared 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 …"
15. 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 U.S. Department of Health and Human Services (HHS) poverty guidelines Web site at aspe.hhs.gov/poverty.
16. Note 1, supra.
17. *Id*.
18. *Id*.
19. 42 C.F.R. 51c.303(f) and 56.303(f).
20. Note 1, supra.
21. Such limitations may be specified by applicable federal and state law for Medicare and Medicaid and/or terms and conditions of private payor contracts.
22. Note 1, supra.
23. HRSA Comments & Response on Draft Policy Information Notice 2014-02, "Clarification of Sliding Fee Discount Program Requirements" bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201402comments.pdf.
24. *Id*.
25. 42 U.S.C. §254b(k)(3)(E) and (F), 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)(G)(ii) and (iii).
29. Note 1, supra.

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