**Sliding Fee Discount Program: Sample Policy and Procedure[[1]](#footnote-1)**

**Policy.**

It is the policy of *[Health Center Name]* (“Health Center”), based on the requirements set forth in Section 330(k)(3)(G) of the Public Health Service Act, 42 C.F.R. § 51c.303(f) and applicable Health Resources and Services Administration policy, to establish a schedule of fees for services, a corresponding schedule of discounts for eligible patients that is adjusted based on the patient’s ability to pay, and supporting operating procedures, including those pertaining to billing and collections.

This sliding fee discount program is designed to assure that Health Center’s patients have access to all services in Health Center’s scope of project, regardless of their ability to pay, while allowing Health Center to maximize revenue sources. The sliding fee discount program will apply to all services provided within Health Center’s federally approved scope of project for which there is an established charge, regardless of service type or mode of delivery.

It is the policy of Health Center that no patient will be denied health services due to an individual’s inability to pay for such services.

Day-to-day direction and management responsibility for implementing the sliding fee discount program rests with Health Center staff under the direction of the Chief Executive Officer (CEO). The Board of Directors will at least annually review this policy, as well as all other policies and operating procedures applicable to the sliding fee discount program, to assess their effectiveness in reducing barriers to care and their appropriateness for the Health Center and its community. This review includes, as appropriate, taking follow-up action to update such policies and/or operating procedures. In addition, Health Center will routinely provide for staff training on implementation of this policy, as well as all other policies and operating procedures applicable to the sliding fee discount program.

**Procedure.[[2]](#footnote-2)**

**1. Establishing the schedule of fees.** Health Center will maintain a Board-approved schedule of fees for the provision of services. The schedule of fees will be used as the basis for seeking payment from patients as well as third party payors. The schedule of fees will be (i) designed to cover reasonable costs of providing services included in the approved scope of project, and (ii) consistent with locally prevailing rates or charges.

To assure that fees are set to cover reasonable costs and are consistent with locally prevailing rates or charges for the services, Health Center establishes its schedule of fees through the following process:

1. Services. Health Center determines the schedule of health center services that will have distinct fees. For example, the fee for a behavioral health visit may differ from the fee for a dental visit.
2. Reasonable costs. Health Center determines the actual costs for providing the services for which there will be a distinct fee.
3. Locally prevailing rates or charges. Health Center researches, reviews and determines charges used by other health care providers in the community for the same or similar services.

Health Center will adjust the schedule of fees, as appropriate, based on regular costs analyses and changes in the local market. All adjustments to the schedule of fees must be approved by Health Center’s Board of Directors.

**2. Establishing the sliding fee discount schedule.** Health Center will establish and maintain a sliding fee discount schedule that adjusts the amounts owed for services by “eligible patients,” as set forth below in section 5. Key features of the sliding fee discount schedule include the following:

1. Health Center will provide a full discount or charge, at most, a fixed fee nominal charge for individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines.

The nominal fee will meet the following criteria:

* It will be considered “nominal” from the perspective of the patient;
* It will be a fixed fee and not a percentage of the actual charge/cost;
* It will not reflect the true cost of the service(s) being provided;
* It will be no more than the fee paid by a patient in the first sliding fee discount schedule pay class above 100 percent of the Federal Poverty Guideline; and
* It will not reflect a minimum fee or payment threshold.

Health Center will review the nominal fee annually to determine whether it continues to meet the aforementioned criteria. In particular, Health Center will determine whether the nominal fee continues to be nominal from the patients’ perspective through a combination of the following:

* Gathering input from annual patient surveys;
* Gathering input from patient board members;
* Reviewing and assessing co-payments under public health insurance programs for low income individuals; and
* Reviewing and assessing collection rates and trends for nominal fee patients.
1. Health Center will discount charges for individuals and families with annual incomes above 100% and at or below 200% of the Federal Poverty Guidelines. There must be at least three discount pay classes and the discounts must be tied to gradations in income level.

[NOTE that as long as the complexity of the sliding fee discount schedule structure does not create a barrier to care, each health center has discretion regarding the structure of their sliding fee discount schedule, including whether to have more than three discount pay classes and what types of discounts to offer (i.e., percentage of fee or fixed/flat fee). However, the *Health Center Site Visit Guide* (Nov 2014) requires that the health center’s SFDP policy and procedure include the “specific structure of all sliding fee discount schedule(s).” Some reviewers have interpreted this requirement to include more specific statements about the sliding fee discount schedule than those in this sample policy, in particular, statements regarding the number of discount pay classes, the corresponding income percentage or flat fee for each level, etc. Accordingly, we advise including such detail in this policy. If the health center has multiple sliding fee discount schedules based on categories of service (e.g., medical, dental, behavioral health), then it should state as much in this policy and procedure and the details of each should be addressed.]

1. Individuals and families with annual incomes above 200% of the Federal Poverty Guidelines will not receive a discount under the sliding fee discount schedule.

The sliding fee discount schedule will be applied uniformly to patients who are eligible, as set forth below in section 5.

The sliding fee discount schedule will be revised annually to reflect updates to the Federal Poverty Guidelines. The sliding fee discount schedule will also be evaluated periodically (at least every three years) for its effectiveness in addressing financial barriers to care and updated, as necessary. All amendments to the sliding fee discount schedule, including the application of any and all nominal fees, must be approved by Health Center’s Board of Directors.

**3. Supplies and equipment**. If Health Center acquires, purchases or facilitates access to supplies and equipment (e.g., eyeglasses and dentures), it reserves the right to charge patients based on a different schedule of discounts. Health Center may charge patients for such supplies and equipment based on amounts that are less than prevailing rates. Further, such charges may be set to cover the reasonable costs of such items or may be further discounted to pass additional savings on to patients.

[Note that, similar to the sliding fee discount schedule, health centers should include specific statements regarding the discounted charges for supplies and equipment in this policy and procedure. For example, if the health center intends to pass through the cost to the patient, the health center’s policy should specifically state such. In addition, health centers should include additional detail regarding provisions to waive or reduce payments on these supplies and equipment consistent with Board-approved policies and the health center’s supporting operating procedures.]

If any patient cannot afford supplies and equipment, Health Center will offer opportunities for payment plans, or if necessary, waivers or reductions of payments, consistent with Section 9. Prior to the provision of a service, patients must be informed of: (1) when the supplies or equipment related to a given service will result in separate charges from the service; (2) what the total amount of out of pocket costs for these supplies or equipment will be; and (3) what, if any, payment plans will be available.

**4. Publicizing discounts.** Health Center [*registration staff*] shall inform all patients about the availability of the sliding fee discount schedule during the new patient registration process and information about the sliding fee discount schedule will be included in new patient packets. In addition, Health Center will provide information regarding the sliding fee discount schedule on Health Center’s website and will post clear notices in waiting rooms and other prominent areas at Health Center’s sites. Information about the sliding fee discount schedule will be available in appropriate languages and at appropriate literacy levels.

**5. Determining eligibility.** Patients will not be required to apply for insurance and be turned down as a prerequisite for eligibility for the sliding fee discount. Eligibility for discounts will be based solely on income and household size under the Department of Health and Human Services’ annual Poverty Guidelines.[[3]](#footnote-3) Health Center will assess income and household size for all patients for UDS purposes and to determine if they are eligible for sliding fee discounts, unless the patient refuses to be assessed.

Income shall include the following:

[Note that the health center’s Board of Directors should determine what to include within the definition of “income.” The Census Bureau uses a standard definition of income for computing poverty statistics based on poverty thresholds that may be used by health centers. The Census Bureau includes the following as income: earnings, unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Health centers may also want to consider definitions that are used by federal programs, such as those based on modified adjusted gross income (MAGI), as defined by HRSA.]

Household shall include the following:

[Note that the health center’s Board of Directors should determine who to include within the definition of “household.” The Census Bureau states that non-relatives, such as housemates, do not count as members of the family. Typically “household” includes the head of household, spouse and dependents. The definition of dependent varies but is often tied to either the IRS rules or alternatively to those individuals the applicant is legally obligated to support.]

**6.** **Eligibility documentation.** The *[financial counselor / financial case manager]* will assist patients in completing an *[income verification form]* and will collect any relevant income verification documentation from patients.

[Note that income verification and other application forms must not request information that could result in a barrier to care. Examples of information requests which could result in a barrier to care include asking patients for information that indicates citizenship or a definition of income different from what HRSA allows.]

Whenever possible, completion of the *[income verification]* form and collection of income verification documentation will occur prior to Health Center’s rendering health care services to the patient, or as soon thereafter as is reasonable, but always prior to the application of the discount. Nonetheless, under no circumstances will health care services be withheld or denied on account of delay of the eligibility documentation process.

New *[income verification]* forms and the collection of relevant income verification documentation will be required of patients on an annual basis or more frequently (e.g., upon a significant change in the patient’s income status). Copies of all *[income verification]* forms and relevant income verification documentation will be retained by Health Center according to Health Center’s established document retention schedule.

[Note that health centers may wish to include a process allowing for a patient to submit a self-declaration regarding their income and/or family size in the event the patient is unable to present the requisite documentation. Any such arrangement must be set forth in policy, applied uniformly to all patients and approved by the Board.]

The eligibility determination process will be conducted in an efficient, respectful, and culturally appropriate manner.

**7. Billing: Application of discounts.** Patients who have completed an *[income verification]* form, have submitted relevant income verification documentation, and who have been found based on their *[income verification]* form and relevant income verification documentation to be eligible for a discount will be charged in accordance with the sliding fee scale or nominal charge, as applicable.

The maximum charge for an insured patient who is eligible for the sliding fee discount schedule will be the maximum amount an eligible patient in that pay class is required to pay for that certain service, subject to Health Center’s legal and contractual limitations.

[Note that 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 may also be eligible for the sliding fee discount schedule based on income and family size. In such cases, subject to potential legal and contractual limitations, the charge for each sliding fee discount schedule 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.]

**8. Collections.** Health Center shall make a reasonable effort to collect all charges for health care services rendered, regardless of whether discounted charges or standard charges are applied. A reasonable effort may include, but is not limited to, issuance of a bill to the patient or responsible party and follow-up with subsequent billing, collection letters, and telephone calls. A patient’s refusal to pay does not equate to an inability to pay.

[Note that the collections process should be set forth with greater specificity in this policy or a separate policy that should be referenced here. For example, the policy should specify if the health center’s billing and collections processes include payment incentives, grace periods, payment plans, or refusal to pay guidelines.]

[Note that if the health center has a separate policy for terminating a patient due to refusal (or unwillingness) to pay, such policy should be referenced here. If the health center reserves the right to terminate patients for unwillingness to pay, the health center must establish 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, meeting with a financial counsel). The policy should also set forth that discharging patients for refusal to pay will be an action of last resort taken only after reasonable efforts have been made to secure payments and/or bill for amounts owed to the health center for services provided, and that the health center will document all steps taken to secure payment from the patient prior to discharging.]

The act of 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.

**9. No denial of services for inability to pay.** Regardless of whether a patient qualifies for a discount, if a patient would be denied services due to inability to pay, then charges will be waived or reduced to the extent necessary to ensure that such patient receives health care services. The provision for waiving fees must be consistently made available for qualified patients.

Criteria for waiver or reduction include:

[Note that health centers must ensure that this policy (or a separate policy) identifies specific criteria that would trigger a reduction or waiver of fees. For example, does the reduction or waiver of fees apply for both initial fees as well as balances, and if the latter, is there a specific balance amount that serves as a trigger? For initial fees, what types of circumstances would qualify for the individualized determination of need (undue financial hardship resulting from immediate events impacting the patient’s ability to pay such as housing, employment, etc.)? In addition, such policies must identify specific staff members with the authority to approve the reduction or waiver of fees.]

**10.** **Training.** Health Center will provide applicable staff with training on this policy.

# **Related policies and procedures.**

* [Sliding fee scale/nominal charge eligibility documentation: Sample form](https://www.healthcentercompliance.com/subscriber/nachc-toolkit/volume-2/141)
* Self-Attestation of Income (if applicable)
* Self-Attestation of No Income (if applicable)

[Note that if any of the aforementioned sections are included in a separate policy and procedure, such as billing and collection, a reference to such policy and procedure should be added here.]

**This policy shall be periodically reviewed and updated consistent with the requirements and standards established by the Board of Directors and health center management, federal and state laws and regulations, and applicable accrediting and review organizations.**

**Responsible Parties:**

### Signature Date

### Chief Executive Officer

Signature Date

1. The Authors of these materials include attorneys at the law firm of Feldesman Tucker Leifer Fidell LLP. The sample documents offer general guidance based on federal law and regulations and do not necessarily apply to all health centers under all facts and circumstances. Further, these materials do not replace, and are not a substitute for, legal advice from qualified legal counsel. [↑](#footnote-ref-1)
2. Using the following sample as a guide, health centers should tailor the procedure to reflect their own health center’s processes and operations. [↑](#footnote-ref-2)
3. The Department of Health and Human Services’ annual Poverty Guidelines are available at: <http://aspe.hhs.gov/poverty/index.cfm>. [↑](#footnote-ref-3)