

POLICY INFORMATION NOTICE

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DOCUMENT NAME: Sliding Fee Discount and Related Billing and Collections Program Requirements

TO: Health Center Program Grantees
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 the establishment of a sliding fee discount program that includes a schedule of discounts for services, or sliding fee discount schedule, and that ensures financial barriers to care are minimized for patients who meet certain eligibility criteria. All section 330-funded health centers and 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 billing and collections requirements.

Health centers that have questions or concerns regarding their individual sliding fee discount and related billing and collections program requirements should contact their Project Officers for assistance. For questions or further policy guidance related to this PIN, please contact the Bureau of Primary Health Care, Office of Policy and Program Development, at BPHCPolicy@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 which include establishing: (1) a schedule of fees for services; (2) a corresponding schedule of discounts for eligible patients that is adjusted based on 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 the organization's supporting operating procedures, including those around billing and collections.

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 subrecipients.² The PIN applies to both Health Center Program grantees and look-alikes.³ Look-alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive the look-alike designation and associated benefits, look-alikes must meet the Health Center Program statutory, regulatory, and policy requirements under section 330 of the PHS Act. 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 look-alikes.

This PIN is the primary HRSA policy resource on the Health Center Program sliding fee discount and related billing and collections program requirements. Therefore, this PIN supersedes all other previous Health Center Program guidance and policy issued on these requirements. Please note, however, that this policy does not supersede either billing requirements resulting from a health center's Federally Qualified Health Center (FQHC) status under Titles XVIII and XIX of the Social Security Act (the Medicare and Medicaid programs), including its implementing regulations or policies, or requirements specified in applicable Funding Opportunity Announcements or Notices of Award (NoAs).

Health Center Program requirements, including those described in this PIN, do not apply to activities outside of a health center's federally approved scope of project. However, it should be noted that such activities are also not eligible for benefits that extend to services/activities within the Federal scope of project, including: use of grant funding, Federal Tort Claims Act (FTCA) coverage, 340B discounted drugs, and FQHC reimbursement under Medicare/Medicaid/Children's Health Insurance Program (CHIP).

¹ The corresponding schedule of discounts will be referred to as the sliding fee discount schedule (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 Section 1861(aa)(4) and §1905(l)(2)(B) of the Social Security Act

III. BACKGROUND

The Health Center Program statute requires health centers 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....”⁴ The Health Center Program statute also requires health centers 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,”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

To comply with these requirements, health centers must implement a sliding fee discount program which assures that health center patients have access to all services in the health center’s scope of project, regardless of their ability to pay, while allowing the health center to maximize reasonable revenue sources. Specifically, the sliding fee discount program must include establishing the following: (1) a schedule of fees for services; (2) a corresponding schedule of discounts for eligible patients that is adjusted based on the patient’s ability to pay; and (3) governing board-approved policies and the organization’s supporting operating procedures, including those around billing and collections.

While the sliding fee discount program supports the concept that patients can be monetarily invested in their care based on their ability to pay, its implementation is intended to minimize financial barriers to care for patients at or below 200 percent of the Federal Poverty Guidelines (FPG). Therefore, neither the fees themselves nor the supporting operating procedures for assessing patient eligibility and collecting payment should create 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. In particular, statute and regulations provide that:⁷

1. Health centers must prepare a schedule of fees for the provision of services that is designed to cover reasonable costs of providing services included in the approved scope of project and that is consistent with locally prevailing rates or charges.⁸ (See Section VI., Fee Schedule.)

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), See also 42 C.F.R. 51c.303(g) and 56.303(g).

⁷ 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).

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>.

2. Health centers must prepare and apply a sliding fee discount schedule (SFDS), so that the amounts owed for health center services by eligible patients are adjusted based on the patient's ability to pay. (See Section VII., Sliding Fee Discount Schedule.) All SFDS must include the following elements:
 - Applicability to all individuals and families with annual incomes at or below 200 percent of the FPG;⁹
 - Full discount for individuals and families with annual incomes at or below 100 percent of the FPG, or allowance for a nominal charge¹⁰ only, consistent with board-approved health center policy;
 - Adjustment of fees (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, including either public health insurance (Medicaid, CHIP, Medicare, and any other public assistance program) or private health insurance (for patients who have such coverage).¹¹ (See Section VIII.A, Billing and Collections: Billing Third Party Payors.)

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.¹² (See Section VI.A, Fee Schedule: Services.) In order to facilitate patient access and utilization, health centers must ensure that: a) patients are made aware of the sliding fee discount program; and b) eligibility for discounts is based on income and family size and no other factors (such as insurance status or population type). Specifically, health centers should establish multiple methods for informing patients of the sliding fee discount program (e.g., signage, registration process). In addition, information about the sliding fee discount program must be available in appropriate languages and literacy levels for the health center's target population.

⁹ 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.

¹⁰ 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. (See Section VII.C, Sliding Fee Discount Schedule: Establishing and Collecting Nominal Charges.)

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

¹² 42 U.S.C. § 254b(k)(3)(G).

V. GOVERNING BOARD OVERSIGHT

Health center governing boards must, as part of their required oversight responsibilities, approve general health center policies, including those associated with the sliding fee discount program. These policies form the foundation for operating procedures.¹³ The approval of the full governing board, with its community based and patient-focused perspective, is the primary mechanism for ensuring that the sliding fee discount program is patient centered, improves access to care, and assures that no patient will be denied health care services due to an inability to pay.

Day-to-day direction and management responsibility for implementing the sliding fee discount program operating procedures rests with health center staff under the direction of the Chief Executive Officer or Executive Director. However, because the board is responsible for ensuring patient accessibility to services, it must periodically review evaluations of these operating procedures¹⁴ and 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 policies and/or directing the CEO to update operating procedures. 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. (See Section VII., Sliding Fee Discount Schedule; Section VIII., Billing and Collections.) At a minimum, the following areas must be addressed:

- Patient eligibility for the SFDS, including definitions of income and family size (including what/who is included or excluded) 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.

The governing board also has discretion regarding certain additional aspects of the health center's sliding fee discount program. If a health center elects to include the following, then the items must be addressed in governing board-approved policies and supporting operating procedures (See Section VII., Sliding Fee Discount Schedule; Section VIII., Billing and Collections.):

- Alternative mechanisms for determining patient eligibility for the SFDS for circumstances in which documentation/verification is unavailable (e.g., self-declaration,

¹³ Health center boards may, but are not required to, provide input in the development of supporting operating procedures that relate to board-approved policies.

¹⁴ As the SFDS must be revised annually to reflect updates to the FPG (See Section VII., Sliding Fee Discount Schedule), the entire sliding fee discount program should also be evaluated at least annually and updated, as appropriate.

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.

VI. FEE SCHEDULE

The fee schedule is intended to generate revenue to cover the health center's costs associated with providing services and assists in ensuring the financial viability and sustainability of the health center. The health center must assure that fees are set to cover reasonable costs and are consistent with locally prevailing rates or charges for the service. The health center's fee schedule must address all in-scope services (required and additional)¹⁵ and be used as the basis for seeking payment from patients as well as third party payors.

The relative weight given to reasonable costs and locally prevailing charges may vary depending on the situation of the health center. For example, new health centers may rely more heavily on locally prevailing charges for constructing a cost-based fee schedule until they have a reliable determination of their own actual costs of operations. In any case, the health center must adjust fees, as appropriate, based on regular cost analyses, as well as changes in the local health care market.

A. SERVICES

The first step in establishing the health center's fee schedule is to determine the schedule of health center 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.¹⁶ Multiple visits (such as those associated with prenatal care) may also 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.

¹⁵ 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.

¹⁶ 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. The definition of these supplies and equipment and the applicability of SFDS are discussed in Section VII.F, Sliding Fee Discount Schedule: Other Considerations.

B. REASONABLE COSTS

In order to establish the fee schedule, the 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 its budget.

Determination of a health center's actual costs requires complex analyses that are not addressed within this PIN. However, for technical assistance, health centers may wish to contact their financial advisor, Primary Care Association, and/or National Cooperative Agreement organizations for additional guidance.

C. LOCALLY PREVAILING CHARGES

Having determined its costs for 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, Medicaid, private providers, or commercial sources.¹⁷ As many private providers do not provide the same comprehensive range of services that health centers provide, health centers may find it challenging when conducting research in this area. If there are no other comparable health care providers in the community, health centers may make comparisons to other, similarly situated communities. In all cases, comparisons should reference commonly used service definitions, which will facilitate both staff and patient understanding of the fee schedule.

VII. 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 a SFDS and without regard to the patient's ability to pay. The SFDS is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all health center patients. While health center fee schedules are designed to cover reasonable costs for providing services, the 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. Once established, the SFDS must be revised annually, at a minimum, to reflect annual updates to the FPG.¹⁸

Consistent with Health Center Program regulations, eligibility for the SFDS is based on a patient's annual income and family size under the U.S. Department of Health and Human

¹⁷ Health centers may wish to seek private counsel when gathering fee-related information from other providers.

¹⁸ 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/>.

Services' (HHS) annual FPG. The health center's governing board must approve in policy, consistent with any Federal, State, or local laws and requirements, its definitions of "family" and "income." Health centers may consider accessing or adapting definitions and documentation from other sources for their use.¹⁹ 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. Once established, these policies and supporting operating procedures must be applied uniformly across the patient population.

A. 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, both for Health Center Program reporting purposes and to assist patients in determining whether they are eligible for sliding fee discounts. It is important that the eligibility determination process be conducted in an efficient, respectful, and culturally appropriate manner to assure that administrative operating procedures for such determinations do not themselves present a barrier to care. Patient privacy and confidentiality must be protected throughout the process.

Some patients may choose not to provide information that the health center requires for assessing income and family size, even after being informed that they may qualify for sliding fee discounts. These patients are declining to be assessed for eligibility for sliding fee discounts. If the health center has followed its policies and supporting operating procedures and the patient declines to be considered for the SFDS, the health center may consider the patient ineligible for such discounts.

Once assessed, 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. In addition to adjusting the SFDS based on annual updates to the FPG, patient eligibility for the SFDS should be renewed/reviewed at least once a year or upon the patient's next visit to the health center. Health centers may establish and implement streamlined SFDS patient eligibility renewal/review procedures that are separate from the initial sliding fee discount screening.

Individuals and families with annual incomes above 200 percent of the FPG are not eligible for sliding fee discounts. However, health centers may receive or have access to other

¹⁹ The Census Bureau uses a standard definition of income for computing poverty statistics based on the poverty thresholds (<http://www.census.gov/hhes/www/poverty/methods/definitions.html>) that may be used by health centers. 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 the IRS.

funding sources (e.g., Federal, State, local, or private funds) that contain terms or conditions for reducing patient costs for specific services. These terms and conditions may apply to patients over 200 percent of the FPG. In such cases, it is permissible for a health center to allocate a portion (or all) of this patient's charge to this grant or subsidy funding source.²⁰

B. SLIDING FEE DISCOUNT SCHEDULE STRUCTURE

In accordance with its SFDS policies, health centers are required to apply a discount to fees charged to patients who have been determined eligible for sliding fee discounts. As noted previously, 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. (See Section VII.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 percent of the FPG,²¹ 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, a 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.²² However, as long as the complexity of its structure does not create a barrier to care, 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 should also be evaluated at least annually for its effectiveness in addressing financial barriers to care and updated, as appropriate.

²⁰ Health centers receiving or accessing such funds must honor the terms of grantors with respect to the use of such funds and charge the appropriate funding source. If questions arise on the appropriate use of other Federal, State, local or private funds, they should be referred to those program sources for additional guidance.

²¹ For example, health centers targeting special populations such as people experiencing homelessness or migratory/seasonal agricultural workers typically serve a large proportion of patients with incomes at or below 100 percent of the FPG.

²² For example, a SFDS with discount pay classes of at or below 100 percent of the FPG, 101 percent up to 125 percent of the FPG, 126 percent to 150 percent of the FPG, 151 percent to 175 percent of the FPG, 176 percent up to and including 200 percent of the FPG, and over 200 percent of the FPG would have four discount pay classes above 100 percent and at or below 200 percent of the FPG.

C. ESTABLISHING AND COLLECTING NOMINAL CHARGES

As required by Health Center Program regulations,²³ health centers must provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG. 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 an 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.²⁴ As they are not intended to create a payment threshold 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.

D. 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 may also be eligible for the SFDS based on income and family size. In such cases, subject to potential legal and contractual limitations,²⁵ 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.²⁶

For example, *John Doe*, an insured patient, receives a health center service for which the health center has established a fee of \$80, per its fee schedule. Based on *John Doe's* insurance plan, the co-pay would be \$60 for this service. The health center has also determined, through an assessment of income and family size, that he is at 150 percent of the federal poverty guidelines (FPG) and thus qualifies for the health center's SFDS. Under the SFDS, a patient at 150 percent of the FPG would receive a 50 percent

²³ 42 C.F.R. 51c.303(f) and 56.303(f).

²⁴ Health centers may find it helpful to seek input from sources such as patient board members, patient surveys, advisory committees, as well as reviewing the co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes to assist with determining what would be considered nominal from the patient perspective.

²⁵ Such limitations may be specified by applicable federal and state law for Medicare and Medicaid and/or terms and conditions of private payor contracts.

²⁶ If, on the other hand, an insured patient's out-of-pocket costs do not exceed his/her SFDS pay class charge, the health center would be permitted but not obligated to provide an additional discount, as long as this is not precluded by the insurance contract terms.

discount of the \$80 fee, resulting in a charge of \$40 for this service. Rather than the \$60 co-pay, the health center would charge *John Doe* no more than \$40 out-of-pocket, consistent with its SFDS, as long as this is not precluded by the insurance contract terms.

As health centers are responsible for ensuring adherence to laws and regulations and for following the terms and conditions of their contracts, they may wish to consult with their third party payors and/or private legal counsel regarding the permissibility of discounting patients' out-of-pocket costs relative to the terms and conditions of private payor contracts.

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 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, as indicated on Form 5A: Services Provided, Columns I, II, or III). Health centers may elect to have multiple SFDS based on services/mode of delivery. Each SFDS must meet all of the following criteria:

- It must conform to the specific structural requirements outlined in this PIN.
- In cases where the health center has elected to establish a nominal charge for patients at or below 100 percent of the FPG, this charge meets the criteria for a nominal charge. (See Section VII.C, Establishing and Collecting Nominal Charges.)
- Patient access and uniform implementation have been taken into consideration in developing each SFDS.
- The health center has a plan for routinely evaluating each SFDS and presenting this information to the board to ensure that it does not create a barrier to care.

For services the health center provides only via a formal written referral arrangement (i.e., Form 5A: Services Provided, Column III within the federally approved scope of project), the health center is responsible for ensuring that the referral provider's discounts for health center patients meet the criteria above. A health center 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 it were applied to the referral provider's fee schedule, as long as:

- 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 were applied to the referral provider's fee schedule; and
- Patients at or below 100 percent of the FPG receive no charge or only a nominal charge (see Section VII.C, Establishing and Collecting Nominal Charges) for these services.

F. OTHER CONSIDERATIONS

As a means of reducing barriers to care and improving health outcomes for its patient population, health centers may acquire, purchase, or facilitate access to supplies and

equipment (e.g., eyeglasses, dentures, prescription drugs, including those purchased under discount programs) from a third party.²⁷ These supplies and equipment are considered related to, but not included in, the service itself as part of prevailing standards of care. If health centers elect to acquire, purchase, or facilitate access to these types of supplies and/or equipment,²⁸ they are permitted to charge patients based on a different structure for discounting than what is described above in Section VI., Fee Schedule and Section VII., Sliding Fee Discount Schedule. To maximize access to these supplies and equipment, health centers may charge patients based on amounts that are less than the locally prevailing rates; however, such charges can be set to cover the reasonable costs of such items or can be further discounted to pass additional savings on to patients. To the extent revenue is generated from charges for these supplies and equipment, the health center must ensure that these non-grant funds are used to further the objectives of the project by benefiting the health center's patient/target population, and for purposes not specifically prohibited under section 330.²⁹

The structure for these charges, if any, and associated payment options should be based on analyses of the health center's patient/target population's needs and support patients' access to these supplies and equipment. In addition, it should include provisions to waive or reduce payments on these supplies and equipment consistent with board-approved policies and the health center's supporting operating procedures. (See Section V., Governing Board Oversight.) In all cases, prior to the provision of a service, patients must be informed of the following: a) when supplies or equipment related to a given service will result in separate charges from the service; b) what the total amount of out of pocket costs for these supplies or equipment will be; and c) what, if any, payment plans will be available.

VIII. BILLING AND COLLECTIONS

Each health center faces challenges 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. Both reimbursement from public and private third party payors and payments from patients provide sources of revenue to ensure this financial sustainability. Sound billing and collections policies and their supporting operating procedures are critical to a health center's ability to carry out both the sliding fee discount program requirement and the requirement to maximize revenue from public and private third party payors.

²⁷ These items differ from supplies and equipment that are included in a service as part of prevailing standards of care and are reflected in the fee schedule (e.g., casting materials, bandages. See Section VI.A, Fee Schedule: Services.)

²⁸ Health centers may wish to consult with private legal counsel regarding risks and/or concerns with providing these supplies and equipment.

²⁹ Refer to PIN 2013-01: Health Center Budgeting and Accounting Requirements for more information on budgeting and accounting requirements for health center scope of project funds and their applicability to section 330 federal grant funds versus non-grant funds.

These billing and collections policies and supporting operating procedures must address billing patients and third party payors within a reasonable period of time after services are provided, typically within 30 days. As a reminder, these procedures must also address maintaining the confidentiality of all personal information and records.³⁰ Patients must be notified of these confidentiality and security protections.

A. BILLING THIRD PARTY PAYORS

Health centers are required to maximize revenue from public and private third party payors.³¹ Section 330 of the PHS Act and implementing regulations require health centers to participate in Title XIX of the Social Security Act (SSA) (Medicaid Program) and Title XXI of the SSA (Children’s Health Insurance Program (CHIP)).³² In addition, health centers are required to make “every reasonable effort” to collect “appropriate reimbursement” from Title XVIII of the SSA (Medicare Program), Medicaid, CHIP, and other public assistance programs, as well as private third party payors used by their patient populations.³³ Although health centers cannot require patients to enroll in public or private insurance and/or related third party coverage, the health center must educate patients on options available to them based on their eligibility for insurance and/or related third party coverage. When determining the specific public and private health insurance plans in which to participate (e.g., Medicaid managed care plans, Qualified Health Plans), health centers should consider their target population(s) and the costs and benefits of such participation.

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.”³⁴ However, since third party payors’ reimbursement rates may be outside an individual health center’s control, the ability to negotiate reimbursement rates may be limited. Nevertheless, health centers must make every reasonable effort to obtain reimbursement from Medicare, Medicaid, CHIP, or other public assistance programs and private third party payors, as applicable, in accordance with requirements specified in statute, regulations, policies and/or contract terms/conditions.

B. BILLING PATIENTS

Health centers must make reasonable efforts to secure payment from patients for services rendered. However, in balancing the statutory requirement of maximizing revenue with ensuring that no patient is denied services based on inability to pay,³⁵ the

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

³¹ 42 U.S.C. § 254b(k)(3)(F).

³² 42 U.S.C. §254b(k)(3)(E) and (F), 42 C.F.R. 51c.303(g) and 56.303(g).

³³ 42 U.S.C. § 254b(k)(3)(F).

³⁴ 42 U.S.C. § 254b(k)(3)(G)(ii)(II).

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

applicable definition of “reasonable” effort may vary depending on elements unique to the individual health center, such as the target population. The act of 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.

1. Provisions for Waiving Charges

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

2. Payment Incentives

Health centers may elect to offer incentives through board-approved billing and collections policies. Such incentives are often referred to as “prompt payment/cash payment incentives,” 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. Health centers should thoroughly research the potential consequences of implementing prompt payment/cash payment incentives for patients and conduct cost-benefit analyses in determining the amount of the payment incentive. 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. In addition, health centers must have a mechanism for communicating the availability of these incentives to all of their patients.

3. Refusal to Pay

There may be instances when patients refuse to pay the amount they owe the health center. If health centers elect to establish policies to address these instances, including discharging patients from the health center, they 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).³⁶

³⁶ It should be noted that if a health center enters into a contract with an outside organization, such as a collections agency, to carry out particular health center policies and supporting operating procedures, the health center must ensure that program requirements continue to be met. Thus, as with any other contractual arrangement, the health

Discharging patients due to refusal to pay is 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 must document all steps taken to secure payment from the patient prior to discharging. Health centers may wish to consult private counsel regarding state requirements and other obligations that may arise in such cases. In addition, consistent with reducing barriers to care, health centers should establish related policies for determining how and when patients may be permitted to rejoin the regular practice at a future date.

IX. EFFECTIVE DATE

This policy is effective upon issuance. HRSA is committed to assisting health centers to remedy identified areas of non-compliance and to providing reasonable time for grantees to take necessary corrective action through the Progressive Action process as described in PAL 2014-08, “Health Center Program Requirements Oversight.”

X. 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 BPHCPolicy@hrsa.gov. Health centers that have questions or concerns regarding their individual sliding fee discount program should contact their Project Officers for assistance.

center must follow their procurement policies and procedures, and maintain sufficient control and oversight over the contracted services. This includes monitoring the contract’s impact on the patients/community, and amending the contract, as needed.