Session 2: Fee/Sliding Fee Discount Schedule

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What does success look like through utilization of the Financial Policy Information Notice (PIN) for health centers?

- We provide the best quality and quantity of services (within our scope of service) for our patients that we can without putting the dental program and/or the rest of the health center programs at risk

Applicability

- Applies to all 330 Program grantees and look-alikes
- PIN does not apply to activities outside of the health center's federally approved scope of project

General Requirements

- **This system must provide a full discount to individuals and families with annual incomes at or below 100% of the poverty guidelines (only nominal fees may be charged)**
  Only two choices here: charge no fee (ie, full discount) or charge a nominal fee
- **For patients with incomes between 101% and 200% of poverty, fees must be charged in accordance with a sliding fee discount policy based on family size and income**
- **Patients with incomes over 200% of the Federal Poverty Guidelines (FPG) are required to pay full fee (No SFSD is allowed)**
  - Non-330 grants or subsidies can be used to reduce any patient's costs of care (example: Ryan White)

General Requirements

- All services within the Scope of Project must be included in the sliding fee discount schedule (SFDS) regardless of service type and made available to all patients regardless of ability to pay
- PIN does not apply to activities outside of the health center's HRSA-approved Scope of Project
- SFDS is based only on family size and income – no other factors
- All patients need to be made aware of the SFDS
- SFDS policy must be fully explained to all patients–users within the CHC using consideration for language and cultural barriers

Governing Board Oversight

- **Health center governing board must approve any policies associated with the sliding fee discount schedule**
  - The health center's governing board must approve its definitions of "family" and "income" in policy, consistent with any Federal, State, or local laws and requirements
- **All aspects of the health centers SFDS program must be based on written policies that have been approved by the governing board and applied uniformly to all patients**
- **The governing board must ensure that the SFDS does not create a barrier to care**

Fee Schedule

- Fees are intended to generate revenue to cover the health center's costs associated with providing services and assist in ensuring the financial viability and sustainability of the health center
- The health center must assure that full fees are consistent with locally prevailing rates or charges
- Fees are used as the basis for seeking payment from patients as well as third party payers

Sliding Fee Discount Schedule (SFDS)

- 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
- Eligibility for the SFDS is based on a patient's annual income and family size under the U.S. Department of Health and Human Services' (HHS) annual FPG
- Once established, the SFDS must be revised annually, at a minimum, to reflect annual updates to the FPG
- The health center would be wise to ensure that discounted fees (with the exception of nominal fees) are set to cover *reasonable* costs

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
1	$11,770
2	$15,930
3	$20,090
4	$24,250
5	$28,410
6	$32,570
7	$36,730
8	$40,890

For families/households with more than 8 persons, add $4,160 for each additional person.

(*Differing poverty guidelines exist for Alaska and Hawaii)*

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http://aspe.hhs.gov/2015-poverty-guidelines

Sliding Fee Discount Schedule (SFDS)

- 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
- Day-to-day responsibility for implementation of the SFDS rests with health center staff under direction of CEO
- Health center staff should be trained on implementation of SFDS policies and all supporting procedures

Determining Patient Eligibility for SFDS

- Health centers must have documented processes in place to assess income and household size for ALL patients
- Patient refusal to provide needed information for sliding fee scale determination can result in ineligibility for the discounts schedule
- Patients will be assessed and deemed eligible based on income and household size receive discounts based on the SFDS
- Patient eligibility for the SFDS should be reviewed at least annually or upon the patient's next visit to the health center

Sliding Fee Discount Schedule Structure

- **Health centers can set their own discount schedule, percentage of discounts and nominal fees they charge but must adhere to the following 2 requirements:**
  - Patients at or below 100% of federal poverty get a full discount (eg, waiver of fees) or are charged a nominal fee
  - The SFDS must have at least three discount pay classes between 101% and 200% of federal poverty tied to gradations in income levels

Establishing and Collecting Nominal Charges

- 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
- 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
- The nominal charge must be less than the fee paid by a patient in the first "sliding fee discount pay class" beginning above 100% of the FPG
- Dental nominal fee can (and most likely should) be different from the medical nominal fee

Insured Patients Who Are Also Eligible for SFDS

- Patients with 3rd party insurance may also be eligible for SFDS based on income and household size
- Health centers are responsible for ensuring adherence to laws and regulations and for following the terms and conditions of their 3rd party contracts
- Health centers may wish to consult with their 3rd party payers or legal counsel regarding the permissibility of discounting patients' out-of-pocket costs
- Generally *if allowed*, the insurance is billed at their normal rate and the patient's portion is discounted based on their sliding fee scale percentage

Multiple Sliding Fee Discount Schedules

- Health centers can have different sliding fee schedules for different service type but each SFDS must conform to PIN requirements
- Each SFDS is applied uniformly across all health center patients
- Each SFDS is regularly evaluated and presented to the governing board to ensure that is does not create a barrier to care
- For services the health center provides only via a formal written referral arrangement, the referral provider must conform with the requirements of the PIN, including the nominal fee for patients at or below 100% of federal poverty

Laboratory Charges

- Costs for items done outside the health centers (3rd party lab charges) are exempt from sliding fee discounts and the actual cost can be charged to the patient (even patients at/below 100% FPG)
- The professional services component of procedures that involve lab charges are subject to all sliding fee discount conditions
- Payment options and lab or separate eligible service costs must be discussed up front prior to services being provided and referenced in written documentation (eg, treatment plans)

Billing and Collections

- Health centers must have sound billing and collections processes
- Patients and 3rd party payers should be billed within 30 days of the provision of services
- Health centers are required to make every reasonable effort to collect from 3rd party payers
- Health centers can't force patients to enroll in private or public insurance plans – but should make patients aware of the options available to them based on their eligibility
- Health centers must balance maximizing revenue and not preventing patients from acquiring services due to inability to pay; however, reasonable efforts to seek payment must be made

Provisions for Waiving Charges

- Health centers must establish policies and supporting operating procedures that define the circumstances when charges can be waived
- These policies and procedures must identify the health center staff who have the authority to waive charges
- The policies and procedures for waiving fees must be applied equally to all health center users
- All policies and procedures related to the waiving of fees must be approved by the health center's governing board

Payment Incentives

- Health centers can offer incentives (discounts) through board-approved billing and collections policies (often referred to as “prompt payment” or “cash payment” discounts)
- These incentives must be available to all health center patients, regardless of income level or sliding fee discount pay class (including nominal fee patients)
- Health centers must have a mechanism for communicating the availability of these incentives to all patients

Refusal to Pay

- Health centers can establish policies to address patients who refuse to pay for care (including discharging patients from the health center)
- Health centers must define 1) what constitutes "refusal to pay"; 2) the circumstances to be considered in determining the patient has refused to pay; 3) the steps to be taken in attempting to encourage patients to pay (eg, grace periods, payment plans, meetings with financial counselor)
- Discharging patients due to refusal to pay should be the action of last resort after all efforts to collect have been exhausted
- The health center must document all steps taken to secure payment from the patient prior to discharging

Key Points from PIN

- The HRSA sliding fee policy under PIN 2014-02 does not apply to services performed by a health center outside of their 330 scope of approved services; however, FTCA malpractice coverage is not available for services provided outside of the HRSA-approved scope
- A minimum of 3 discount categories must exist within the sliding fee scale between 101% and 200% of federal poverty

Key Points from PIN

- The nominal fee is a flat fee and not a percentage fee within the sliding fee scale –it is for patients at or below 100% of federal poverty
- Percentage-based fees apply to patients between 101% and 200% of federal poverty
- Providers performing services on behalf of the health center under written agreement or contract must provide the health center's nominal and sliding fee scale discounts

Key Points from PIN

- Health centers can pass along outside lab costs to uninsured patients
- Health centers need a formal policy defining the process of waiving charges
- Health centers can offer prompt pay discounts but these discount must be available to all patients (eg, if patients get a 10% discount for paying at the time of the visit, even a nominal fee patient paying $30 would get a 10% discount for paying at the time of the visit)
- Health centers can discharge patients for refusal to pay but this should be an action of last resort

Actions to Consider

- Reviewing all intended or provided dental services, performing a cost analysis on each and making informed decisions about scope, nominal fee, and sliding fees in dental
- Decisions should not be made on guess work, instinct or intuition but should be made using timely, meaningful and accurate data to inform those decisions
- The governing board must approve all decisions related to fees, sliding fee discounts, nominal fees and payment for dental care

Primary Care Drives Governance PINs

- Because 80-85% of the services provided in health centers are provided in the primary care setting, the formulation of governance PINs are made around that primary care medical service delivery model. It is often not reasonable nor feasible to take all of the governance contained in a PIN and simply apply those to dental services.
- Retrofitting these PINs to dental does not always work perfectly. They require that we think them through and through informed justification create policies that do fit. It requires utilizing an informed decision making process. Without this approach we put the dental program at risk.

Key Elements to Making Informed Decisions on Sliding Fee Discounts, Nominal Fees, and Scope of Service:

- You need to know how dental supply costs, staffing, equipment, procedures, and operational expenses impact your program
- Know HRSA's practice goals for dental programs and service expectations
- Understand that most health center dental clinics have 1/5th of the capacity of their medical clinics
- These variances between medical and dental will impact your costs and your sliding fee discount determinants differently than the medical program

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Key Cost Related Data to Help Determine Scope of Service

- Cost per visit (Expenses divided by number of visits)
- Lab, supplies, time, and costs for each procedure
- Reports on services provided by ADA code (transaction report)
- Calculation of RVUs for all services divided by expenses (determines the cost for each RVU provided)

Where is There Wiggle Room?

- Remember 330 scope of project services = required sliding fee discount schedule = FTCA federal malpractice coverage
- Outside of scope of practice = no sliding fee discount schedule requirement = need for private malpractice policy