

Comments & Response on Draft Policy Information Notice, “Clarification of Sliding Fee Discount Program Requirements”

In July 2012, the Health Resources and Services Administration (HRSA) made the draft Program Information Notice (PIN), “Clarification of Sliding Fee Discount Program Requirements,” available for public comment. The purpose of this PIN is to convey and clarify statutory and regulatory requirements regarding the sliding fee discount program for all Health Center Program grantees (Section 330(e), (g), (h), and (i) grantees) and look-alikes.

Fifty-one parties, including both individuals and groups, submitted a total of 326 comments regarding the draft PIN. After review and careful consideration of all comments received, HRSA amended the PIN to incorporate certain recommendations and suggestions from the public. The final PIN reflects these changes. Below is a summary of major comments and HRSA’s responses. Please note that minor changes to the PIN may have been incorporated that are not summarized below.

Issue: Applicability of the PIN to Health Care for the Homeless and Public Housing Primary Care Grantees

Comments

One commenter suggested the PIN be recommended and not required for health care for the homeless and public housing primary care health centers.

HRSA Response

This PIN applies to all health centers, funded under the Health Center Program authorized in section 330 of the Public Health Service Act, as amended. The PIN also applies to look-alikes, as they must meet the statutory, regulatory and policy requirements for health center program grantees under section 330. However, HRSA recognizes the unique challenges of serving special populations, and has expanded language throughout the PIN to emphasize that health centers must consider their patient population and barriers to care when establishing and evaluating their sliding fee discount programs.

Issue: Governing Boards’ Understanding of Expectations

Comments

Ten commenters suggested the role of the governing board in establishing policies for sliding fee scales be clarified. The commenters further stated the board should not have a role in establishing or implementing procedures and operations.

HRSA Response

HRSA is addressing these concerns by creating a “Governing Board Oversight” section in the PIN. Health center governing boards are responsible for approving general health center policies, including those associated with the sliding fee discount program. These policies form the foundation for the supporting operating organizational procedures. Because the board is responsible for ensuring patient accessibility to services, it must periodically review evaluations of these operating procedures 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.

Issue: Determining Reasonable Costs for the Fee Schedule

Comments

Seven commenters stated HRSA should clarify that fee schedules may include non-clinical services, such as enabling services, provided such services are currently billed and/or reimbursed separately within the local health care market.

HRSA Response

HRSA recognizes this concern and added a statement in the PIN clarifying that enabling services that are typically billed and/or reimbursed separately within the local health care market may be part of the health center's fee schedule.

Issue: Determining the Costs of Providing Services

Comments

Ten commenters stated the PIN should clarify that in developing the fee schedule, health centers may make comparisons to similarly situated communities where no other local health care providers exist and should check with counsel prior to gathering fee-related information from other providers given the potential for antitrust issues.

HRSA Response

HRSA acknowledges that health centers may find conducting research in this area challenging, and the PIN clarifies if no other comparable health care providers are in the community, health centers may make comparisons to other, similarly situated communities. The PIN also notes that health centers may wish to seek private counsel when gathering fee-related information from other providers.

Issue: Determining Eligibility for Sliding Fee Discounts

Comments

Eight commenters stated HRSA should clarify that a patient's application for third party coverage is not a condition for eligibility for a sliding fee scale discount or to receive services.

HRSA Response

HRSA clarifies in the PIN that eligibility for sliding fee discounts is based on income and family size. Procedures for determining sliding fee discount eligibility must not create a barrier to care. In addition, assisting patients with obtaining third party coverage is separate from assessing patients for sliding fee discount eligibility.

Issue: Clarifying Definitions of Income and Family Size

Comments

Nine commenters stated HRSA should provide standard, uniform definitions of family size and income.

HRSA Response

Due to the uniqueness of each health center's patient population, 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." 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. Therefore, HRSA declines to provide standard definitions across all health centers.

Issue: Determining the Structure of the Sliding Fee Scale

Comments

Thirteen commenters expressed concern that HRSA was imposing structural requirements upon the SFDS that went beyond what was explicitly stated in statute or regulations.

HRSA Response

In order to ensure that health center fee scales are sliding in nature, HRSA has revised the final PIN to clarify that a SFDS must have multiple pay classes (at least three) tied to gradations in income levels above 100 percent and at or below 200 percent of the FPG in order to adjust charges based on ability to pay. Each health center has discretion regarding how it structures the SFDS within this construct, including the number of discount pay classes, and the types of discounts (percentage of fee or fixed/flat fee for each discount class) it offers.

Issue: Eliminating Charges for Patients at 100-200% of the Federal Poverty Guidelines

Comments

Two commenters recommended HRSA allow boards the discretion to provide a full discount to patients at 100 percent to 200 percent of the Federal Poverty Guidelines, as charges may be a significant barrier to care at these income levels.

HRSA Response

HRSA is unable to implement this recommendation as it directly contradicts the regulatory requirements. However, health centers are required to develop policies and supporting operating procedures that include provisions for waiving fees and nominal charges for specific patient circumstances.

Issue: Clarifying Discounts for Patients with Incomes Above 200% of the Federal Poverty Guidelines

Comments

Six commenters requested clarification on the use of other payor sources (such as other Federal funds or state funding), which require discounts for patients above 200% of the FPG, where less than the full charge can be covered by the alternate payor source.

HRSA Response

The PIN clarifies that 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 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.

Issue: Defining a Nominal Charge

Comments

Eleven commenters stated HRSA should provide more guidance on defining a nominal charge. Others specifically commented that the nominal charge should not create a barrier to care.

HRSA Response

HRSA provides additional clarification on defining nominal charges, specifically that electing to establish a nominal charge is at the discretion of the health center and any health center choosing to establish a nominal charge must ensure 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. 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. In addition, the nominal charge is not intended to create a payment threshold for patients to receive care and should therefore not be referred to as a “minimum fee,” “minimum charge,” or “co-pay”.

Issue: Eliminating the Nominal Charge for Patients below 100% of the Federal Poverty Guidelines

Comments

One commenter stated that patients at 100% and below the Federal Poverty Guidelines should be charged no nominal charge because a charge of any size is a barrier to care for these patients.

HRSA Response

Health Center Program regulations (42 C.F.R. 51c.303(f)) state that a nominal charge “for services **may** be collected from individuals with annual incomes at or below such levels where imposition of such fees is consistent with project goals.” However, electing to establish a nominal charge is an individual health center decision. HRSA clarifies this in the PIN.

Issue: Waiving Fees and Nominal Charges

Comments

Six commenters stated HRSA should provide more clarity on procedures for waiving fees, including, nominal charges. One commenter suggested moving this section to the billing and collections section, since it applies to waiving all fees and charges, and not just waiving nominal charges.

HRSA Response

This section has been moved to the billing and collections section, and HRSA has made this a separate section in the PIN. HRSA clarifies that health centers must establish board-approved policies and supporting operating procedures that include provisions for waiving fee(s) and nominal charges for specific patient circumstances. These policies and supporting operating procedures must 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.

Issue: Clarification on Payments Due to the Health Center from Patients At or Below 200% of the Federal Poverty Guidelines

Comments

Fifteen commenters stated HRSA should clarify that the sliding fee discount applies to co-payments, deductibles, and out-of-pocket expenses for eligible patients, subject to applicable federal law for Medicare and Medicaid and the terms and conditions of private payors.

HRSA Response

HRSA recognizes the concerns raised in these comments, and clarifies in the PIN 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 SFDS based on income and family size. In such cases, subject to potential legal and contractual limitations, 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.

Issue: Applicability of the sliding fee discount to services that are not required but are in scope

Comments

Six commenters recommended HRSA provide clearer guidance on whether health centers must provide sliding fee discounts for services that are not required but are in scope (i.e., non-related dental services, specialty care, etc.).

HRSA Response

HRSA clarifies in the PIN that 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, and as indicated on Form 5A: Services Provided, Columns I, II, or III).

Issue: Allowing for Multiple Sliding Fee Scales

Comments

Six commenters stated HRSA should clarify that multiple sliding fee discount schedules be treated consistently in terms of documentation and approval, rather than requiring additional documentation for multiple sliding fee discount schedules.

HRSA Response

After considering this comment, HRSA has modified the PIN to not require additional documentation for multiple sliding fee discount schedules. The PIN clarifies that if a health center elects to have multiple SFDS based on services/mode of delivery, each SFDS must meet the SFDS criteria listed in the PIN, including requirements around the following: structure; nominal charges; considering patient access and uniform implementation as part of development; and evaluation.

Issue: Supporting Flexibility with Referral Arrangements

Comments

Seven commenters requested the PIN provide for greater flexibility with referral arrangements. Commenters also recommended HRSA reduce the requirement for referral SFDS to a recommendation.

HRSA Response

In response to this comment, HRSA is including additional language addressing SFDS requirements as they apply to referral arrangements. 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 (i.e., Form 5A, Column III), the health center must ensure the services are available to its patients regardless of their ability to pay and offered on a SFDS. This SFDS does not need to be the same as the health center's SFDS. HRSA is also allowing further flexibility by permitting a health center to 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.

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.

Issue: Applying the Sliding Fee Discount Schedule to Supplies or Equipment that are Integral or Incident to the Provision of Services

Comments

Nine commenters requested clarification on what is considered a supply or equipment that is “integral” or “incident to” part of the provision of a given service. Commenters also wanted further guidance on how to handle more costly alternatives. In addition, a few commenters raised questions about whether health centers may apply the sliding fee discount schedule to only the service (i.e., fitting/placement), where the large portion of the cost is from the supplies (i.e., dentures).

HRSA Response

HRSA clarifies that the intent of this section is to describe supplies and equipment (such as dentures, eyeglasses, prescription drugs, including those purchased under discount programs) that the health center may acquire, purchase, or facilitate access to from a third party as a means of reducing barriers to care and improving health outcomes for its patient population, and that 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, they are permitted to charge patients based on a different structure for discounting than what is described in the PIN 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. Health centers may wish to consult with private legal counsel regarding risks and/or concerns with providing these supplies and equipment.

Issue: Applying the Sliding Fee Discount Schedule to Prescription Drugs

Comments

Seven commenters requested clarification on the application of the sliding fee discount schedule to pharmaceuticals/prescription drugs.

HRSA Response

HRSA clarifies that prescription drugs (including those purchased under discount programs) would generally be classified as a supply that the health center may acquire, purchase, or facilitate access to from a third party as a means of reducing barriers to care and improving health outcomes for its patient population. Thus, they are permitted to charge patients for prescription drugs based on a different structure for discounting than what is described in the PIN 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. Health centers may wish to consult with private legal counsel regarding risks and/or concerns with providing these supplies and equipment.

Issue: Deleting References to Billing and Collections

Comments

Eight commenters stated HRSA should delete the entire section on “Billing and Collections” from the PIN, as the topic is not part of a sliding fee discount schedule.

HRSA Response

While HRSA recognizes that “billing and collections” is a separate concept from the sliding fee discount schedule, many policies and procedures associated with billing and collections are critical components in implementing the sliding fee discount program and the intent to ensure patients have access to services regardless of their ability to pay, while balancing the need for financial sustainability. In response to these comments, HRSA has focused this section on the billing and collection requirements that relate to a health center’s sliding fee discount program and has retitled the PIN to include this topic.

Issue: Clarifying Requirements for Eligibility Assistance

Comments

Seven commenters stated the PIN should clarify that health centers are only required to assist patients with applying for coverage through public insurance and not private insurance.

HRSA Response

HRSA recognizes the challenges in working with multiple payors, but it is a requirement for health centers to maximize revenue from both public and private third party payors. Although health centers cannot require patients to enroll in insurance and/or related third party coverage, health centers must educate patients on all options available based on their eligibility for insurance and/or related third party coverage. Enrollment assistance activities also support health centers’ efforts in to maximize revenue from these payor sources as well as assist patients in accessing a wider range of health services.

Issue: Participating in Private Health Insurance Plans

Comments

Nine commenters recommended to HRSA that the PIN recognize the right of health centers to walk away from poorly constructed private insurance contracts and those that do not cover the reasonable costs of providing covered services.

HRSA Response

HRSA recognizes the concerns reflected in the comments and clarified that health centers must make “every reasonable effort” to collect reimbursement for services provided to persons covered by private health insurance “on the basis of the full amount of fees and payments for such services without application of any discount.” The PIN further clarifies that in many cases an individual health center’s ability to negotiate the actual third party reimbursement rates for services may be limited. 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 the target population and the costs and benefits of such participation.

Issue: Determining Reasonable Efforts to Collect Payments from Patients

Comments

Eight commenters stated HRSA should clearly describe what it considers reasonable efforts to collect payment from patients.

HRSA Response

HRSA recognizes the concerns conveyed by this comment and clarifies that health centers are required to make reasonable efforts to secure payment from patients in a manner that ensures no patient will be denied services based on an inability to pay. HRSA further clarifies that the definition of “reasonable effort” may vary depending on elements unique to the health center, such as service area and target population.

Issue: Implementing Billing Fees

Comments

Four commenters recommended HRSA remove the language that health centers implement billing fees only after analyzing the likelihood of receiving payment from a patient.

HRSA Response

HRSA has deleted the language around billing fees. Decisions about if, and how, to implement billing fees remain a matter of individual health center policy, so long as they do not create a barrier to care.

Issue: Eligibility for Payment Incentives

Comments

Three commenters suggested that prompt payment or cash payment incentives to patients who pay with cash and/or who pay their bills within a specific expedited timeframe should only be offered to patients who do not qualify for the sliding fee discount schedule as opposed to all patients of the health center.

HRSA Response

HRSA clarifies in the PIN that health centers may elect to offer incentives, 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. These payment incentives are for the benefit of the health center and not the patient. Therefore, they must be accessible to all patients, regardless of income level or sliding fee discount category and consistently applied without preferential treatment of any kind.

Issue: Addressing Patients Refusal to Pay

Comments

HRSA received twelve comments requesting clarification on what constitutes refusal to pay by patients.

HRSA Response

After considering these comments, HRSA clarifies that health centers electing to have “refusal to pay” policies must define what constitutes “refusal to pay” on an individual health center basis. Such policies must specifically address what individual circumstances are to be considered in making such determinations and what enforcement steps are to be followed when these situations occur. 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.