Sliding Fee Scale Discount Guide for Critical Access Hospitals and Rural Health Clinics

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PREFACE

This guide is developed to provide critical access hospital (CAH) and rural health clinic (RHC) executives and management teams with concepts and guidance in developing a Sliding Fee Scale Discount Program. It is also designed to assist in gaining an understanding of how sliding fee scale discount programs relate to Internal Revenue Code Section 501(r) compliance and participation in the National Health Service Corps (NHSC).

The materials in this guide do not constitute and should not be treated as professional advice regarding the use of any particular financial strategy or the consequences associated with any technique. Every effort has been made to ensure the accuracy of these materials. The National Rural Health Resource Center (The Center), Eide Bailly LLP, and the authors do not assume responsibility for any individual's reliance upon the written information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular fact situation and should independently determine the correctness of any particular sliding scale fee discount program planning technique before recommending the technique to a client or implementing it on the client's behalf.

SLIDING FEE SCALE DISCOUNT PROGRAM

A sliding fee scale discount program adjusts the amount an eligible patient owes for health care services based on the patient's ability to pay. Sliding fee scales are a means of addressing the need for equitable access to health services for all individuals.

While the methodology may vary, sliding fees are typically based upon the Federal Poverty Guidelines (FPG) and patient eligibility is determined by annual income and family size. Schedules are established and implemented to ensure that a non-discriminatory, uniform, and reasonable charge is consistently and evenly applied to all qualifying patients. A sliding fee scale discount program should be developed in accordance with locally prevailing rates or charges and should be designed to cover the facilities' reasonable costs of operation. They should also be designed to cover costs of providing a service while addressing financial barriers to care.

In a perfect world, the sliding fee scale discount program would be supported by and integrated into the practice management system. This would allow for a more efficient and effective process and allow for easier and earlier identification of patients that are potentially eligible for assistance through a sliding fee scale discount program.

REASONS TO IMPLEMENT A SLIDING FEE DISCOUNT PROGRAM

There are several reasons a facility may wish to consider the use of a sliding fee discount program.

1. The early detection of collectable amounts on account balances
2. Meeting the requirements of 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r)
3. Allowing a facility to become a National Health Services Corps approved site

What follows is further consideration of each of these above listed reasons.

Early Detection of Collectable Balances

Hospitals and clinics often spend inordinate amounts of time attempting to collect balances from patients who do not have the ability to make the full payment. Eventually, after great collection effort has been expended, the balances are written-off to bad debt. A well-structured sliding fee discount program will promote early detection of the more reasonably collected balance and can significantly reduce the time and effort expended attempting to collect uncollectible amounts. The time saved in this process can allow staff to increase the time they have available to collect accounts with greater opportunity. Additionally, the early detection of collectable balances can have a positive impact on the overall patient experience by reducing unnecessary anxiety over anticipated financial responsibilities that are ultimately discounted or completely resolved through the discount program.

Consideration for 501(r) Compliance

To be granted and maintain non-profit status as a 501(c)(3), hospitals and clinics owned by a 501(c)(3) hospital are required to meet four general requirements on a facility-by-facility basis:

- Establish a written financial assistance policy (FAP) and Emergency Medical Care Policy

- Limit amounts charged for emergency and other medically necessary care to individuals eligible for assistance under the hospital organization's FAP
- Make reasonable efforts to determine whether an individual is eligible for assistance under the hospital organization's FAP before engaging in extraordinary collection actions against the individual
- Conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA
- In defining medically necessary care for purposes of a FAP and the Amounts Generally Billed (AGB) limitation, a hospital facility may, but is not required to, use the Medicaid definition used in the hospital facility's state, other definitions provided by state law, or a definition that refers to the generally accepted standards of medicine in the community

The Affordable Care Act (ACA), enacted March 23, 2010, added these new requirements for organizations that operate one or more hospitals. Internal Revenue Code Section 501(r) requires all non-profit hospitals and clinics owned by a non-profit hospital to develop a FAP. A FAP must specify all financial assistance available under the FAP, to include all discounts and free care, and, if applicable, the amount(s) to which any discount percentages will be applied. For example, the discount off of the gross amount charge.

501(r) limits the amounts charged for emergency or medically necessary care provided to individuals eligible for assistance under the organization's FAP to not more than the AGB. One of two methods can be used to determine the AGB: the Look-Back Method and the Prospective Method.

The Look-Back Method

Under the Look-Back Method, a hospital or clinic must determine AGB for any emergency or other medically necessary care provided to an FAP-eligible individual by multiplying the gross charges for that care by one or more percentages of gross charges, called AGB percentages. Hospital facilities or clinics must calculate their AGB percentage(s) at least annually by dividing the sum of all its claims for emergency or other medically necessary care that have been allowed certain health insurers during a prior 12-month

period divided by the sum of the associated gross charges for the same claims.

$$\text{Look-Back AGB} = \frac{\text{Total Allowed Charges (see below)}}{\text{Total Associated Gross Charges}}$$

More specifically, these AGB percentages must include the claims allowed during the 12-month period by:

- Medicare fee-for-service alone;
- Medicare fee-for-service and all private health insurers paying claims to the hospital facility;
- or, Medicaid, either alone or in combination with Medicare and all private health insurers.

For these purposes, a hospital or clinic may include in “all claims that have been paid in full” both the portions of the claims paid by Medicare, or the private insurer and the associated portions of the claims paid by Medicare beneficiaries or insured individuals in the form of co-insurance, copayments, or deductibles.

A hospital or clinic choosing the look-bath method may calculate the AGB percentage as an average of all gross charges or may calculate multiple AGB percentages for separate categories of care (such as inpatient care and outpatient care) or for separate items or services, as long as the hospital or clinic calculates AGB percentages for all emergency and other medically necessary care provided by the facility or clinic.

A hospital or clinic is allowed to take up to 120 days after the end of the 12-month period used to calculate the AGB percentage(s) to begin applying its new AGB percentage(s).

The Prospective Method

Under the Prospective Method, a hospital or clinic may determine AGB for any emergency or other medically necessary care that the hospital or clinic provides to an FAP-eligible individual by using the same billing and coding process the hospital or clinic would use if the individual were a Medicare fee-for-service beneficiary or Medicaid beneficiary. The hospital or clinic would then set AGB for that care at the amount the hospital facility determines

would be the amount Medicare or Medicaid would allow for the care (including the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, and deductibles).

The average charges generally billed limitation applies to all individuals eligible for assistance under the hospital/clinic facility's FAP, without specific reference to the individual's insurance status. An FAP-eligible individual is charged only the amount he or she is personally responsible for paying, after all deductions and discounts (including discounts under the FAP) have been applied and less any amounts reimbursed by insurers.

A sliding fee schedule must, at a minimum, provide discounts that meet these requirements.

If the RHC were a freestanding RHC (not owned by an entity licensed as a hospital) or part of a for profit organization, then 501(r) would not apply.

National Health Service Corps Participation

The mission of the National Health Service Corps (NHSC) is "to expand primary health care to those who need it most" (2015). Since 1972, the NHSC has been building healthy communities, ensuring access to health care for everyone, preventing disease and illness, and caring for the most vulnerable populations who may otherwise go without care. NHSC-approved sites may be able to improve their ability to recruit providers due to scholarships and student loan repayment incentives that are provided to participants. NHSC supports clinical sites that provide comprehensive medical, dental and/or behavioral health care to all regardless of ability to pay. The statutory requirements of the program stipulate, "the entity shall prepare a corresponding schedule of discounts (including, in appropriate cases, waivers) to be applied to the payment of such fees or payments. In preparing the schedule, the entity shall adjust the discounts based on the patient's ability to pay."

To comply with these requirements, NHSC-approved sites must implement a sliding fee discount program, which ensures that patients have access to all primary health services regardless of their ability to pay. Specifically, the sliding fee discount program must include:

1. a schedule of fees for services;

2. a corresponding schedule of discounts for eligible patients;
3. and, policies and operating procedures, including those around applying for the discount program.

The sliding fee scale discount program must include the following elements:

- Be applicable to all individuals and families with incomes at or below 200 percent of the most current FPG
- Provide full discount for individuals and families with annual incomes at or below 100 percent of the FPG, or allowance for a nominal charge only, consistent with the site's policy
- Adjust fees based on family size and income for individuals and families with incomes above 100 and at or below 200 percent of the FPG
- The required fees and the process of assessing patient eligibility and collecting payment must not create barriers to care

Hospitals and clinics must also make every reasonable effort to obtain reimbursement from third party payers, including either public health insurance such as Medicaid, Medicare or other public assistance programs, or private health insurance for patients who have such coverage.

NSHC approved sites must also ensure patients are made aware of the sliding fee scale discount program and that eligibility for discounts is based on income and family size but no other factors, such as assets and insurance status. The site must not require Medicare, Medicaid, or Children's Health Insurance Program (CHIP) application or proof of denial before allowing a patient to apply and be eligible for the Sliding Fee Discount Program. Individual patient eligibility for the Sliding Fee Discount Program should be reviewed or renewed at least once a year or upon the patient's next visit (if more than 12 months have passed). Each site must establish multiple methods of notifying and informing patients about the discount program such as displaying notices about the discount program in common areas and, if one exists, on the facility's website. NSHC-approved sites must be in a Health Professional Shortage Area (HPSA) and information about the sliding fee scale discount program must be made available in the appropriate language and literacy levels for the site's HPSA population.

A facility should have a sliding fee scale discount program in place for at least six continuous months prior to applying to become an NHSC-approved site. At the time of application, recertification and site-visit, the following sliding fee scale discount program documentation must be submitted:

- Sliding Fee Discount Program Policy;
- Sliding Fee Schedule;
- Patient application for the Sliding Fee Scale Discount Program;
- And, posted signage notifying patients about the Sliding Fee Scale Discount Program.

For additional information on the NHSC's requirements for sliding fee scale discount programs, please refer to the NHSC Site Reference Guide, pages 9-13.

DEVELOPING A SLIDING FEE SCHEDULE DISCOUNT PROGRAM

In order to establish a sliding fee schedule discount program, a hospital or clinic must undergo the process of setting policies and creating a sliding fee scale discount structure. What follows are considerations for undertaking each of these processes, referencing guidelines, recommendations and regulations from the Centers for Medicare and Medicaid Services (2004), the U.S. Department Health and Human Services (2018 and 2022) and the Internal Revenue Service (IRS) (2021).

Setting Policies

The first step in implementing a sliding fee scale discount program is to develop discount program operating policies. All aspects of the program should be based on written policies that are applied uniformly to all patients and are further supported by the operating procedures. At a minimum, the following areas should be addressed in the policies and procedures.

- Patient eligibility for the sliding fee scale discount, including definitions of family size and income, as well as who or what is included or excluded in those definitions
- Alternative mechanisms for determining patient eligibility for circumstances in which documentation or verification is unavailable
- Frequency of re-evaluation of patient eligibility
- Sliding Fee Discount Program advertisement to the patient population
- Provisions for waiving fees and nominal charges for specific patient circumstances
- Policy explanation of establishing and collecting nominal charges
- Use of multiple sliding fee scale discount schedules, if applicable
- Other provisions related to billing and collections to include payment incentives, grace periods, payment plans, or refusal to pay guidelines

The facility’s governing board should oversee and approve the policies associated with the sliding fee scale discount program. The approval of a community-based board is the primary mechanism for ensuring that the sliding fee scale discount program is patient-centered, improves access to

care, and ensures that no patient will be denied health care services due to inability to pay.

Creating a Sliding Fee Scale Discount Structure

The normal charges of a hospital or clinic are intended to generate revenue in order to cover the facility's costs associated with providing services and assist in ensuring the financial viability and sustainability of the facility. The facility needs to ensure that its fees are set as to cover reasonable costs. Another factor for consideration are charges used by other health care providers in the community for the same or similar services as to not over price services for the local market which can lead to public perception issues.

Once a facility has established its fee schedule, it then needs to consider establishing a corresponding sliding fee scale discount structure (see Appendix for example). There are multiple factors to consider when developing the structure, such as income and family size, number of discount pay classes, and types of discounts. Each of these are explained in more depth below.

Income and Family Size

The Federal Register notice does not define what income is to be counted nor whose income is to be included in a household or family unit; there is discretion here. However, income is generally considered to be the gross income reported for federal income tax purposes. The individuals whose income is to be included is the head of household, spouse, and their dependents. The definition of dependent varies but is often either tied to the IRS rules or, alternatively, to those individuals the applicant is legally obligated to support. An NHSC-approved site must define in policy its definitions of "income" and "family size".

Listed below are some examples of income that may be counted to determine eligibility.

- Gross wages
- Tips
- Social Security
- Social Security Disability

- Veteran’s benefits
- Pensions
- Alimony
- Child support
- Military payments
- Unemployment
- Public aid
- Spouse’s income if living with the individual

Number of Discount Pay Classes

In order for the sliding fee scale discount schedule to be structured in a manner that adjusts based on ability to pay, the schedule needs to have at least three discount pay classes; below 100 percent, above 100 percent, and at or below 200 percent of the FPG. In addition, these discount pay classes must be tied to gradation in income levels. For example, a sliding fee scale discount schedule with discount pay classes 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. See the Appendix for an example of a sliding fee scale discount schedule.

Each hospital or clinic has discretion regarding how to structure its sliding fee scale discount schedule if the complexity of the structure does not create a barrier to care. The sliding fee scale discount schedule should be revised annually to reflect updates to the FPG. The structure of the sliding fee scale discount schedule should be evaluated at least annually for its effectiveness in addressing financial barriers to care.

Type of Discounts

Sliding fee scale discount programs may utilize different types of discounts based on what works best for the facility. Some may choose to discount a percentage of the fee schedule charge for a service or to create a fixed/flat fee for each discount pay class. The type of discount used for the sliding fee scale schedule is up to the discretion of the individual facility.

As a method of increasing collections and reducing billing costs, the hospital or clinic may also offer payment incentives to patients who pay with cash or who pay their bills within a specified timeframe, such as prompt pay or cash payment discounts. The facility should research the potential consequences of implementing prompt pay or cash payment incentives and conduct a cost-benefit analysis to determine the appropriate payment incentive.

In addition to the development of policies, procedures and a fee scale discount schedule, hospitals and clinics should routinely provide staff training regarding implementation of sliding fee discount program policies and related operating procedures.

USING A SLIDING FEE SCALE DISCOUNT PROGRAM AT YOUR ORGANIZATION

Once the sliding fee scale schedule is developed, it should be used to determine the discount to which a patient is entitled based on the criteria for income and family size. Income and family size should be determined at the time of the initial visit, such as intake or during the admission process. Income and family size should also be validated at least annually to assign patients to the correct pay class.

At the time of the patient visit, the full charge for the services provided to a patient should be recorded for billing purposes. For example, imagine a patient comes to the clinic for an office visit. The patient has a family of four with an annual income of $48,000. The charge for the office visit is $200. Referencing the example sliding fee schedule in the Appendix, based on family size and annual income, the patient is expected to pay 60 percent of the charge, or $120 for this visit. All efforts should be made to collect the patient’s $120 payment in accordance with the hospital’s established billing and collection policies and procedures. The full charge of $200 should be recorded in the general ledger and the patient’s account, with an entry to reflect the value of the discounted service documented as an adjustment against the full charge.

CONCLUSION

A sliding fee scale discount program should be considered by CAH and RHC leaders as it can be beneficial to both providers and patients. It allows some facilities to meet their IRS non-profit requirements and others to meet the eligibility requirements of an NHSC-approved site. A sliding fee scale discount program can help facilitate overall collections efforts and generate additional revenue in circumstances where patients may have been "no pay" prior to the implementation of a discount program. Finally, the program helps many organizations meet their mission as it enables greater access to care by reducing or eliminating financial barriers for their patients.

REFERENCES

Centers for Medicare and Medicaid Services. (2004, February 17). *Questions on Charges for the Uninsured.* Retrieved from CMS Medicare Fee-for-Service Payment Website

Internal Revenue Service. (2021, September 7). *Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r)*. Retrieved from IRS Website

National Health Service Corps. (2022, March). *NHSC Site Reference Guide*. Retrieved from NHSC Downloads

U.S. Department of Health and Human Services. (2022, January 12). *U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs*. Retrieved from HHS Poverty Guidelines

U.S. Department of Health and Human Services Health Resources and Services Administration. (2018, January). *Sliding Fee Discount Program.* Retrieved from HRSA Health Center Program Compliance Manual: Chapter 9: Sliding Fee Discount Program

APPENDIX: EXAMPLE SLIDING FEE SCHEDULE

Annual Income Thresholds by Percent Poverty and Sliding Fee Discount Pay Class

Family of 1	Family of 2	Family of 3	Family of 4	Family of 5	Family of 6	Family of 7	Family of 8	Each additional person	Poverty Level	Patient Payment Responsibility
$13,590	$18,380	$23,030	$27,750	$32,470	$37,190	$41,910	$46,630	+ $4,720	100%	Minimum Fee ($5)
$16,988	$22,888	$28,788	$34,688	$40,588	$46,488	$52,388	$58,288	+ $4,720	125%	20%
$20,385	$27,465	$34,545	$41,625	$48,705	$55,785	$62,865	$69,945	+ $4,720	150%	40%
$23,783	$32,043	$40,303	$48,563	$56,823	$65,083	$73,343	$81,603	+ $4,720	175%	60%
$27,180	$36,620	$46,060	$55,500	$64,940	$74,380	$83,820	$93,260	+ $4,720	200%	80%
$27,180 +	$36,620 +	$46,060 +	$55,500 +	$64,940 +	$74,380 +	$83,820 +	$93,260 +	$4,720	> 200%	100%

Note: From U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Programs. HHS Poverty Guidelines for 2022. Federal Register Notice, January 12, 2022.