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Chapter 9: Sliding Fee Discount Program

Note: This chapter contains language that was revised based on a technical correction. [View the revisions.](#) (PDF - 583 KB)

Authority

Section 330(k)(3)(G) of the PHS Act; 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u)

Requirements

- The health center must operate in a manner such that no patient shall be denied service due to an individual's inability to pay.¹
- The health center must 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 and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)] to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.
- The health center must establish systems for [sliding fee] eligibility determination.
- The health center's schedule of discounts must provide for:
 - A full discount to individuals and families with annual incomes at or below those set forth in the most recent [Federal Poverty Guidelines \(FPG\)](#) [100% of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
 - No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG].

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

- a. The health center has a sliding fee discount program² that applies to all **required** and **additional health services**³ within the HRSA-approved **scope of project** for which there are distinct fees.⁴
- b. The health center has board-approved policy(ies) for its sliding fee discount program that apply uniformly to all patients and address the following areas:
 - Definitions of income⁵ and family;
 - Assessment of all patients for sliding fee discount eligibility based only on income and family size, including methods for making such assessments;
 - The manner in which the health center's sliding fee discount schedule(s) (SFDS(s)) will be structured in order to ensure that patient charges are adjusted based on ability to pay; and
 - *Only applicable to health centers that choose to have a nominal charge for patients at or below 100% of the FPG:* The setting of a flat nominal charge(s) at a level that would be nominal from the perspective of the patient (for example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes) and would not reflect the actual cost of the service being provided.⁶
- c. For services provided directly by the health center (**Form 5A: Services Provided**, Column I), the health center's SFDS(s) is structured consistent with its policy and provides discounts as follows:
 - A full discount is provided for individuals and families with annual incomes at or below 100% of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100% of the FPG.
 - Partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.⁷
 - No discounts are provided to individuals and families with annual incomes above 200% of the current FPG.⁸
- d. For health centers that choose to have more than one SFDS, these SFDSs would be based on services (for example, having separate SFDSs for broad service types, such as medical and dental, or distinct subcategories of service types, such as preventive dental and additional dental services) and/or on service delivery methods (for example, having separate SFDSs for services provided directly by the health center and for in-scope services provided via formal written **contract**) and no other factors.
- e. The health center's SFDS(s) has incorporated the most recent FPG.
- f. The health center has operating procedures for assessing/re-assessing all patients for income and family size consistent with board-approved sliding fee discount program policies.
- g. The health center has records of assessing/re-assessing patient income and family size except in situations where a patient has declined or refused to provide such information.

- h. The health center has mechanisms for informing patients of the availability of sliding fee discounts (for example, distributing materials in language(s) and literacy levels appropriate for the patient population, including information in the intake process, publishing information on the health center's website).
- i. For in-scope services provided via contracts (Form 5A: Services Provided, Column II, Formal Written Contract/Agreement), the health center ensures that fees for such services are discounted as follows:
- o A full discount is provided for individuals and families with annual incomes at or below 100% of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100% of the FPG.
 - o Partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.
 - o No discounts are provided to individuals and families with annual incomes above 200% of the current FPG.
- j. For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center ensures that fees for such services are either discounted as described in element "c." above or discounted in a manner such that:
- o Individuals and families with incomes above 100% of the current FPG and at or below 200% of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and
 - o Individuals and families at or below 100% of the FPG receive a full discount or a nominal charge for these services.
- k. Health center patients who are eligible for sliding fee discounts and have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class.⁹ Such discounts are subject to potential legal and contractual restrictions.¹⁰
- l. The health center evaluates, at least once every three years, its sliding fee discount program. At a minimum, the health center:
- o Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services;
 - o Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
 - o Identifies and implements changes as needed.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines whether to establish a nominal charge for individuals and families at or below 100% of the FPG.
 - The health center determines how to document income and family size in health center records.
 - The health center determines whether to take into consideration the characteristics of its patient population when developing definitions for income and family size and procedures for assessing patient eligibility for SFDS. For example, the health center may consider the availability of income documentation for [individuals experiencing homelessness](#), build in cost of living considerations when calculating income, permit self-declaration of income and family size.
 - The health center determines how and with what frequency to re-assess patient eligibility for the SFDS.
 - The health center determines whether to identify individuals who refuse to provide information on income and family size as ineligible for SFDS.
 - The health center determines how to make patients aware of sliding fee discounts (for example, signage, registration process).
 - The health center determines:
 - Whether to establish more than three discount pay classes above 100% of the FPG and up to and including 200% of the FPG;
 - What income range to establish for each discount pay class above 100% of the FPG and up to and including 200% of the FPG;
 - What method to use for discounting fees above 100% of the FPG and up to and including 200% of the FPG (for example, percentage of fee, fixed/flat fee per discount pay class); and
 - Whether to establish multiple SFDSs (for example, separate SFDSs for medical services and dental services) including, if appropriate, different nominal charges for each SFDS.
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Footnotes

1. See Chapter 16: [Billing and Collections](#) for more information on waiving or reducing charges due to a patient's inability to pay.
2. A health center's sliding fee discount program consists of the schedule of discounts that is applied to the fee schedule and adjusts fees based on the patient's ability to pay. A health center's sliding fee discount program also includes the related policies and procedures for determining sliding fee eligibility and applying sliding fee discounts.
3. See Chapter 4: [Required and Additional Health Services](#) for more information on requirements for services within the scope of the project.
4. A distinct fee is a fee for a specific service or set of services, which is typically billed for separately within the local health care market.
5. Income is defined as earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings.

6. Nominal charges are not “minimum fees,” “minimum charges,” or “co-pays.”
7. For example, a SFDS with discount pay classes of 101% to 125% of the FPG, 126% to 150% of the FPG, 151% to 175% of the FPG, 176% to 200% of the FPG, and over 200% of the FPG would have four discount pay classes between 101% and 200% of the FPG.
8. See Chapter 16: [Billing and Collections](#), if the health center has access to other grants or subsidies that support patient care.
9. For example, 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 the patient’s insurance plan, the co-pay would be \$60 for this service. The health center also has determined, through an assessment of income and family size, that the patient’s income is 150% of the FPG and thus qualifies for the health center’s SFDS. Under the SFDS, a patient with an income at 150% of the FPG would receive a 50% 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 the patient no more than \$40 out-of-pocket, consistent with its SFDS, as long as this is not precluded or prohibited by the applicable insurance contract.
10. Such limitations may be specified by applicable Federal or state programs, or private payor contracts.

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