DEVELOPMENT OF A SLIDING FEE SCALE

Community Health Center, Migrant Health Center, and Black Lung Program grantee organizations are required by Federal legislation to provide health services at reduced charges for patients who qualify by virtue of their income and family sizes. The Poverty Income Guidelines are revised each year; each revision is published in the Federal Register. The intent of this instruction is to illustrate the development of a discount scale that can be applied to the total full charges for the visits of those patients who qualify.

Step 1: Determining The Number Of Steps In The Discount Schedule:

Federal regulations require that reductions in fees range from zero pay (or minimum charge) for individuals at or below the poverty level for family size to full charge for individuals at twice the poverty level for the family size. The number of discount steps is to be determined by the grantee organization. The following example uses the 2001 Poverty Income Guidelines in a 25% incremental scale. Other numbers of steps may be used (for example 20% or 10% increments), but as the number of steps increases, so does the complexity for determining each client's status within this scale. The design of a sliding scale discount schedule should best fit the needs of the grantee organization (to generate income) and the target population (to prevent financial barriers to care.) In selecting the patient fee discount categories, it is important to remember that too few categories may either classify many patients at the lower end, thereby reducing income for the organization, or at the upper end, discouraging patients from seeking care because of the fees, thereby also reducing the income of the organization.

Step 2: Determine Family Income Baseline By Family Size:

The current Federal Poverty Income Guideline, issued by DHHS each year, should be consulted for the base figures to use in the rows and columns of the discount schedule. The first column indicates the number of members in the client's immediate family, and this should range from one to whatever number that you expect to be within the sizes of the patient families that utilize your center. Then, under the Zero Percent (%) Column, enter the poverty level income by family size, taken from the current Federal Poverty Income Guidelines. This establishes the minimum fee (or "Zero-pay") income levels for each family size. As a example, a family of three with an income of $14,630 or less would qualify for discounted service at the minimal fee (or "Zero-pay") level.

Step 3: Determine Family Income Ceiling By Family Size:

The family income shown in the 0% Column is doubled to determine the upper income limit by family size (the income level above which family members pay full charges.) Enter this figure in the "100% Pay" Column for each family size. Continuing the example, for a family of three the ceiling would be two times the Zero-pay amount, or [2 x $14,630], equaling $29,260.

Step 4: Calculate The Income Ranges For Each Payment Category:

The following formula illustrates the calculation for any number of intermediate levels in the scale:

\[
\frac{\text{Baseline Income Figure}}{(\text{Number of Categories Minus 2})} = \text{Increase of Dollar Range from Preceding Step}
\]

Continuing to use the example of a family with three members, the discounted payment schedule ranges from a base income of $14,630 to a maximum of $29,260, i.e., at an income above $29,260, the fees may not be discounted. Therefore in this example and using twenty-five percent increments, there are three more intervening steps (25%, 50%, and 75% discounts,) each comprising a column that needs to be calculated. Consequently, the incremental figure for a family of three is:

\[
\frac{\$14,630}{(5-2)} = \frac{\$14,630}{3} = \$4,877 \text{ (rounded to nearest dollar)}
\]

Figures should be rounded to the nearest dollar amount in order to eliminate fractions of a dollar. In this example, the upper limit of each income category will be approximately $4,877 (rounded) to greater than the preceding category, up to $28,300:

<table>
<thead>
<tr>
<th>Base</th>
<th>+</th>
<th>Increment</th>
<th>=</th>
<th>Next Level</th>
<th>Column</th>
</tr>
</thead>
<tbody>
<tr>
<td>$14,630</td>
<td></td>
<td>$4,877</td>
<td>=</td>
<td>$19,507</td>
<td>25% Column</td>
</tr>
<tr>
<td>$19,506</td>
<td></td>
<td>$4,877</td>
<td>=</td>
<td>$24,383</td>
<td>50% Column</td>
</tr>
<tr>
<td>$24,383</td>
<td></td>
<td>$4,877</td>
<td>=</td>
<td>$29,260</td>
<td>75% Column</td>
</tr>
</tbody>
</table>

The lower limit in each category is simply $1 greater that the upper dollar amount in the preceding column.

Step 5: Using the Sliding Fee Scale:

Once the form has been completed, it should be used to determine the discount to which a patient is entitled based on the criteria of annual income and family size. Income and family size must be determined at the time of the initial visit (intake or admission interview) and should be validated at least annually to assign patients to payment categories.

At the time of the visit, the full value of services provided to a patient should be recorded for billing purposes. For example, a member of a family of three with an annual income of $18,000, who utilizes the clinic's services for an adult initial complete history and physical. Assuming the charges for this procedure are $150.00, the patient would be expected to pay 25% of the charge, or $37.50 for this service. If a minimum fee has been established for any service, either the discounted charge or the minimum fee, whichever is greater, should be imposed, and efforts should be made to collect this amount in accordance with the organization's established billing and collection policies and procedures. Full charges are to be recorded on the books, and an entry should be made to reflect the value of the discounted service as an adjustment against full charges.

The Center's Discount Schedule should be reviewed each year to ensure conformity with current Federal Poverty Income Guidelines, which are generally revised in February or March of each year. Approval of revised rates should be reflected in minutes of actions by the Board of Directors.