Assessing Column III Arrangements for Program Requirement #7: Sliding Fee Discounts: Frequently Asked Questions for MSCG Consultants

Q: What documentation should consultants review in order to assess whether an individual formal written referral arrangement (Form 5A: Services Provided, Column III) between a health center and a referral provider is compliant with the Sliding Fee Discount Scale (SFDS) Program Requirement (either meets the SFDS requirements or results in a “Good Deal” exception/flexibility for referred services)?

A: Review the formal written referral agreement(s), for specific language about how discounts are provided to patients referred by the health center. This may include a copy of the referral provider’s SFDS. Review the discount policy/scale of the referral provider to determine if it meets the HRSA program requirements, or provides a “good deal” as defined in PIN 2014-02 (See Section VII. E: Sliding Fee Discount Schedule: Multiple Sliding Fee Discount Schedules).

Alternatively, the formal written referral arrangement may make general references to the referral provider’s SFDS, discount program, or “good deal” (e.g., charity care program), but not contain specific language describing these discounts. For example, the agreement may not necessarily include the actual referral provider’s SFDS. In these circumstances, the health center would need to make available for review a copy of the referral provider’s SFDS or other discount program in order to facilitate an assessment of the arrangement. The written referral arrangement itself does not need to be revised as long as other documentation has been provided demonstrating the referral provider’s discounts meet the SFDS requirements or provide a “good deal.” For example, a referral arrangement with a hospital system, which provides a full discount to patients up to 200% of FPG would be considered a “good deal” and would meet the HRSA program requirements.

Q: How should the sliding fee requirements for services provided via formal written referral arrangements (Form 5A: Services Provided, Column III) be assessed during the OSV?

A: In order to ensure a thorough review of all program requirements when reviewing services provided through formal referral arrangements, the OSV team’s priority is to review any Required Services that are provided ONLY via Formal Referral Arrangements - Health Center Does Not Pay (Column III on Form 5A), as documented in the health center’s scope of project (Form 5A: Services Provided). This is often a joint team effort between the clinical reviewer and the financial reviewer.

For services provided to patients at or below 200% of the Federal Poverty Guidelines (FPG) via a referral arrangement, compliance with the sliding fee discount program requirement must be met as follows:

- The referral provider offers a Sliding Fee Discount Schedule (SFDS) for the referred service(s) that meets the structural requirements (i.e., no charge or only a nominal charge for those at or below 100% of the FPG, three pay classes between above 100% and at or below 200% of the FPG, no discount above 200% of the FPG, etc.) described in PIN 2014-02 (but does not necessarily have to match the structure or discount of the health center’s own SFDS); OR
The referral provider offers discounts that exceed the structural requirements (e.g., discounts above 200% of the FPG, all patients at or below 250% of the FPG are not charged, etc.) of PIN 2014-02, but meet the following minimum standards (i.e. a “good deal”):

- Discounts offered to all health center patients for the referred service are greater than patients would receive under the health center’s SFDS policy if it were applied to the referral provider’s fee schedule.
- Patients at or below 100% of the FPG receive no charge or are only charged a nominal fee.

When a required service is provided to health center patients at or below 200% of the FPG through a referral arrangement, but the referral provider does not discount by either of the two methods above, this referral arrangement would be assessed as not meeting the sliding fee requirements under Program Requirement #7 for a formal referral agreement (i.e. Column III). If the health center does not provide this required service through another mode of delivery to patients at or below 200% of the FPG, then this compliance finding would be noted by the consultant in the sliding fee requirement section, as instructed in the site visit guide.

If the site visit team has questions as to whether the sliding fee arrangement for a particular service meets the requirements, they should fully document what is found onsite in the site visit report and highlight or indicate any key questions or areas of clarification for the Project Officer.

**Q: What if a service meets all of the requirements of a formal referral agreement except for sliding fee?**

**A:** When a service is provided to health center patients with incomes at or below 200% of the FPG through a referral arrangement, but the referral provider does not offer discounts for the service that meet the sliding fee requirements of a formal referral agreement as described above, this arrangement would be considered an informal referral arrangement. Therefore, it should not be included in Column III for Form 5A: Services Provided, since it is not part of the HRSA-approved scope of the project. In cases where the referral arrangement is for an additional service, there is no finding of non-compliance, as the health center can correct their scope of project by removing these Column III services after the site visit.

In cases where the service is a required service, this would not meet the sliding fee requirement and would only be documented under Program Requirement #7: Sliding Fee Discounts, as instructed in the site visit guide.

**Q: How do I analyze a Column III referral agreement for compliance under Program Requirement #7: Sliding Fee Discounts in a situation where a health center is providing a service via multiple modes of delivery (e.g., Column III and Column I and/or Column II)?**

**A:** The key to analyzing a situation where a health center is delivering a service via more than one mode of delivery is to document that the health center can ensure the patient’s ability to pay does not pose a barrier to accessing the service for patients at or below 200% of the FPG. In practice, a health center may ensure such access to a particular service through a combination of multiple modes of delivery, as long as this combination of arrangements provides all patients (those at or below 200% of the FPG and patients above 200% of the FPG) with reasonable access to the service via some mode of service delivery.
For example, a health center may have an agreement with a hospital for a required service such as radiology, but that agreement may only provide for discounts for patients at or below 150% of the FPG. In this situation, the formal referral agreement should be analyzed to see if it is compliant with the “good deal exception” in PIN 2014-02 for those health center patients at or below 150% of the FPG. This would include ensuring that patients at or below 100% of the FPG receive either a full discount or only pay a nominal charge, and that patients between 100% and 150% of the FPG receive a discount that is at least as good as or better than if the service fee was discounted using the health center’s own SFDS. Additionally, the health center would have to demonstrate that all patients not eligible for discounts under this particular Column III referral agreement (patients with incomes between 150-200% of the FPG) with the hospital are able to access the required radiology service on a sliding fee via another mode of delivery. The health center could satisfy this requirement by having a Column II contract with the hospital where the health center pays the hospital a contractual amount for these services for those patients between 150% and 200% of the FPG, or the health center could provide the same radiology services directly (Column I) and apply its own sliding fee discount program.