



*Strengthening Oklahoma's Safety Net,
One Community At A Time*

Board Bulletin

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Affordable Health Care Based on Ability to Pay

Over the past few months, many have questioned community health centers (CHCs) need to collect fees from patients given the program expectation “to see all people regardless of *ability* to pay.” Board members, as ambassadors of the health center, must know how CHC grant funding works relative to patient fees to effectively answer questions from legislators and the community at large. Section 330 CHCs are federally funded to provide health care for those below 200% Federal Poverty Level (FPL). Even with grant funding, CHCs have finite resources to deliver comprehensive care – including medical, oral and behavioral health. As part of the grant requirements, CHCs must provide an array of services beyond the traditional office visit including enabling assistance (e.g., case management, transportation, health education, outreach) to promote positive health outcomes and reduce health care costs through preventive action. When CHC patients pay for their share of fees according to ability, health centers can use resources to help more in need of health care thereby increasing access for all.

A Closer Look at Affordable Health Care

◆ **Ability vs. Willingness** – Policy Information Notice (PIN) 98-23 states “Health centers must provide access to services without regard for a person’s ability to pay.” It is important to note that it does not say “willingness to pay.” The Health Resources and Services Administration (HRSA) expects CHCs to collect sliding fees from patients below 200% FPL and to have systems in place for that purpose. Just as no one goes to a store without expecting to pay for their goods, people should not be conditioned to think CHCs provide free care.

◆ **Sliding Fee Scale** - 330 grant funding enables CHCs to provide affordable health care to all by using a sliding fee scale tied to poverty levels. The Federal Poverty standards are reviewed and updated annually and are published in the Federal Register (usually by mid-February). CHC boards should review and approve an updated sliding fee schedule once the new FPL guidelines are released each year. Boards should also review the CHC’s minimum fee to see if it has been reasonably adjusted through the years to reflect the FPL income increases and the rising costs of providing services. Increasing minimum fees so that patients pay a fair share as they are able helps CHCs use resources to increase access for more people that would otherwise be unserved.

◆ **Patient Income Verification** – The Uniform Data System (UDS) is an accountability tool used by HRSA/BPHC to ensure that CHCs are using grant dollars appropriately. CHCs are required to submit UDS reports in February for the previous calendar year. UDS Tables include information relative to services offered, staff and utilization, revenue, financial costs, and patient demographics such as age, gender, race/ethnicity, and socioeconomic characteristics. Table 4 requires CHCs to report patient income by categories tied to FPL. This table shows whether the grant dollars are reaching the intended population – those patients below 200% FPL. As shown in the attached Oklahoma 2006 UDS Summary, 33.1% of Oklahoma CHC patients were listed as “Unknown” income - which is much higher than the national percentage of 22.8%. It is important for CHCs to have systems that accurately record patient income. This begins with board policies regarding patient registration and proof of income requirements. *CHC patients should only be allowed to receive a sliding fee discount if they are willing to produce proof of income. Each CHC needs to review their patient registration systems and make adjustments if the “Unknown” patient income percentage is high. Otherwise it may adversely impact grant funding if the CHC cannot clearly demonstrate that those below 200% FPL are being served.*

◆ **Leveraging Resources** – While CHCs receive grant funding to help offset the costs of providing discounted services, they must also have solid collection policies. HRSA/BPHC looks closely at grant dollars in proportion to number of patients served. If we know that \$150 grant dollars per general community user is a guideline used in CHC grant applications and the average annual cost of providing care to CHC patients is \$450, basic math tells us how important it is to collect established fees so affordable health care will be available to all.

To review OPCA’s entire *Board Bulletin* series, visit the ‘CHC Boards’ section of www.okpca.org.

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