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TO: Local Health Directors
Participants in the 5/22 Teleconference on "Health Check: Revised Billing Requirements"

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DATE: June 2, 2003

SUBJECT: Sliding Fee Scales and "Flat Fees"

At the May 22 teleconference, there was a question about the use of "flat fees" and the application of sliding fee scales. In my answer I referenced a memo sent to local health departments. However, in checking my files, I discovered that we sent guidance out to consultants that they could use in answering questions on this issue, but we did not send a communication on this issue to locals. Therefore, with this memo I am correcting that oversight.

A number of factors influence the answer to a specific question about whether a local health department may apply a "flat fee" to a service provided in the agency: the description of the service; whether the service is provided to individuals with Medicaid coverage, private insurance and/or self-pays; whether third party payors cover the service and how it must be billed; the Program in which the service is provided; relevant statutes and Administrative Code; and the requirements of specific types of funds.

The first "rule" to consider is that "your charge is your charge"; i.e., you may not vary your charge by payor source but you may accept a variety of reimbursements as full payment for that service (e.g. you might have a charge of \$100 for a service, but accept as full payment: \$92 from Medicaid; \$85 from a particular industry in your community with whom you have negotiated a discounted rate; and \$0, \$20, \$40, \$60, \$80 or \$100 from self-pays, depending on where they fall on the sliding fee scale.)

Second, for all women's and children's health services, 15A NCAC 21B .0109 (a)(2) and (3) apply: "If a local provider imposes any charges on clients for maternal and child health services, such charges...(2) will not be imposed on low-income individuals or their families; (3) will be adjusted to reflect the income, resources, and family size of the individual receiving the services." This means that, in all cases for WCH Programs, the sliding fee scale must be applied and it must slide to zero (\$0.00).



Third, Medicaid policy clearly states that “in no case shall charges for services provided to Medicaid clients exceed charges for that service to the general public.” (See attached other Medicaid rules.)

In response to two specific questions posed to the WCH Section, we received the following guidance:

1) May a LHD establish a “flat fee” for a pregnancy test?

Answer: If this test is done in any WCH Program, the sliding fee scale must be applied to your charge. However, if the service is provided in a “general clinic” which is not supported by any Healthy Mothers, Healthy Children (HMHC) funding, the WCH Program would allow the agency to charge a “flat fee” (i.e., to not apply the sliding fee scale or to apply a sliding fee scale which does not slide to zero.) However, you must also take into account Medicaid policy. Since this is a service that may be billed to Medicaid, the third “rule” (see top of this page) applies. Therefore, if you set a charge (which in general clinic as noted above could be your “flat fee”) that is lower than the Medicaid rate, you must also bill that lower charge anytime you bill Medicaid for a pregnancy test - whether in WCH programs or general clinic. One option could be to set your charge at the Medicaid rate or actual cost, whichever is higher, and to apply the WCH sliding fee scale in HMHC-supported programs and a sliding fee scale which does not slide to zero for non-HMHC supported clinics.

2) May a LHD establish a “flat fee” for a sports or camp physical?

Answer: If – in order to bill Medicaid for eligible children – the agency elects to perform the required elements and bill these services as Interperiodic Health Check visits, then it must use that fee as the base for billing all clients for that service and utilize a sliding fee scale for payment.

In the case of sports and camp physicals only, if the agency elects to perform an abbreviated history and physical (that does not include all the Health Check requirements but is based only on the items included on the specific form) the agency may pursue either of two options:

1. Health departments may arrange their funding to provide sports or camp physicals without any use of Healthy Mothers, Healthy Children funds (either to support staff salaries or any other expense). If this is done, they may charge a flat fee to all families. The efforts some local agencies have engaged in to secure alternative funding sources for families for whom the fee is a hardship are to be commended. In this scenario, all clients must be informed “up front” that no third party payors (Medicaid or private insurance) will be billed and they will be responsible for the total cost “out-of-pocket
2. Health departments may use Healthy Mothers, Healthy Children funding in the provision of sports and camp physicals. In this case, both the Social Security Act (governing Title V) and the NCAC language quoted above clearly require that the sliding fee scale be used. However, this process can be streamlined. For example, LHDs may ask parents to provide family size/family income information up-front "if they want to be considered for a sliding fee scale (e.g. reduced or no fee) for this service." Parents already are required to fill out the medical history portion of the sports or camp physical form and sign a consent form for both the service and allowing their child's participation in the sports/camp activity. The request for information about income/family size would be an added request that the parent could complete if they wish to be considered for a reduced fee. Any parent could choose not to fill in that section and would be then charged the total flat fee. Families eligible for a sliding fee scale adjustment would be charged less (up-front).

For either choice, the Health Check Program wants Medicaid-eligibles to be informed that Medicaid pays for the more comprehensive physical (i.e. Interperiodic). If they choose the more limited physical they must pay “out of pocket.

I hope this guidance is helpful to you. We want to make sure that you are aware of federal, state and Medicaid-specific limitations on charging patients for services provided so that, if audited, you would not be in a payback or worse, illegal, situation.

10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS

- (a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services but will charge the patient for all services provided.
- (b) Acceptance of a patient as a Medicaid patient by a provider includes, but is not limited to, entering the patient's Medicaid number or card into any sort of patient record or general record-keeping system, obtaining other proof of Medicaid eligibility, or filing a Medicaid claim for services provided to a patient. A patient, or a patient's representative, must request acceptance as a Medicaid patient by:
 - (1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing; or
 - (2) stating either orally or in writing that the patient has Medicaid coverage; or
 - (3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.
- (c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:
 - (1) for allowable deductibles, co-insurance, or co-payments as specified in 10A NCAC 22C .0102; or
 - (2) before the service is provided the provider has informed the patient that the patient may be billed for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the limits on Medicaid services as specified under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or
 - (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services are received but has failed to supply a Medicare number as proof of coverage; or
 - (4) the patient is no longer eligible for Medicaid as defined in 10A NCAC 21B.
- (d) When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when:
 - (1) the provider failed to follow program regulations; or
 - (2) the agency denied the claim on the basis of a lack of medical necessity; or
 - (3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.
- (e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment plus any authorized deductible, co-insurance, co-payment and third party payment as payment in full for all Medicaid covered services provided, except that a provider may not deny services to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance or co-payment amount as specified in 10A NCAC 22C .0102. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this

Paragraph, a provider may actively pursue recovery of third party funds that are primary to Medicaid.

- (f) When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services covered by Medicaid with the exception of any third party payments or cost sharing amounts as described in 10A NCAC 22C .0102.

History Note: Authority G.S. 108A-25(b); 108A-54; 150B-11; 42 C.F.R. 447.15;

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