Sliding Fee Scale Guide for Cash Practices

A Practical Framework for Pricing Reduced-Fee Care

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About This Guide

A sliding fee scale gives you a consistent way to offer lower prices to patients with limited financial resources without guessing from patient to patient.

You can use it for:
• Membership fees
• Cash-pay visits
• Procedures
• Other services

The first question is: How much reduced-fee care can my practice afford to provide?

Quick Start

To create your sliding fee scale:
1. Know how much revenue your practice needs.
2. Know your realistic patient or visit capacity.
3. Calculate what the average patient or visit needs to generate.
4. Decide how many discounted patients or visits you can afford.
5. Set your discount levels.
6. Decide who qualifies.
7. Put the policy in writing.
8. Use the application and renewal forms at the end.

Step 1: Know Your Numbers

Before offering discounts, know what the practice needs to generate financially.

Include:
• Staff wages and benefits
• Rent
• Technology
• Malpractice and business insurance
• Supplies
• Professional services
• Marketing
• Banking and merchant fees
• Administrative expenses
• Debt payments
• Physician compensation
• Operating reserve
• Desired profit or margin

Do not leave physician compensation out of the calculation.

If You Have a Membership Practice

Use: Required Annual Revenue ÷ Realistic Panel Size = Required Average Annual Revenue per Patient

Example: Required annual revenue $600,000; realistic panel size 600 patients.
$600,000 ÷ 600 = $1,000 per patient per year

That does not mean every patient has to pay $1,000. Your entire patient mix needs to average about $1,000 per patient for the model to work.

If You Have a Fee-for-Service Practice

Use: Required Annual Clinical Revenue ÷ Realistic Annual Visits = Required Average Revenue per Visit

Example: Required clinical revenue $500,000; realistic annual visits 4,000.
$500,000 ÷ 4,000 = $125 per visit

You can also calculate required revenue per clinical hour if that better reflects how you practice.

Step 2: Decide How Much Discounted Care You Can Offer

Once you know what the practice needs, model reduced pricing.

Membership Example

Standard membership: $100/mo | Annual: $1,200 | Desired panel: 500 patients

If everyone paid full price: 500 × $1,200 = $600,000

Now assume you offer a reduced membership at $60 per month. Annual reduced membership: $60 × 12 = $720. Difference from full price: $1,200 - $720 = $480 per patient.

If 50 patients receive that price: 50 × $480 = $24,000 less annual revenue. Projected annual membership revenue becomes $576,000.

Now compare $576,000 with what your practice needs. If your practice needs $590,000, you cannot support 50 patients at that price without changing something else.

You May Need To:

- Offer fewer discounted memberships
- Reduce the discount
- Increase standard pricing
- Reduce expenses
- Increase capacity if that still fits your practice
- Accept a lower owner return if you intentionally choose to do so

Fee-for-Service Example

Standard established visit: $150 | Reduced visit price: $90

Difference: $60 per visit. If you expect 100 reduced-fee visits: 100 × $60 = $6,000 less annual revenue.

Now decide whether the practice can absorb that reduction. Repeat the calculation for other services you plan to discount.

Step 3: Choose a Discount Structure

Example Discount Structure

There is no single required discount schedule. The percentages need to fit your financial model. A simple starting structure might look like this:

Household Income → Discount → Patient Pays
Above 200% of applicable HHS guideline → 0% → 100% of standard price
151%–200% → 20% discount → 80% of standard price
101%–150% → 40% discount → 60% of standard price
Up to 100% → 60% discount → 40% of standard price

These percentages are examples only. Run the financial calculations before adopting them.

Membership Example

If your standard membership is $100 per month:

Household Income → Discount → Monthly Price
Above 200% → 0% → $100
151%–200% → 20% → $80
101%–150% → 40% → $60
Up to 100% → 60% → $40

Fee-for-Service Example

If your standard office visit is $150:

Household Income → Discount → Visit Price
Above 200% → 0% → $150
151%–200% → 20% → $120
101%–150% → 40% → $90
Up to 100% → 60% → $60

You may choose smaller or larger discounts. Another practice may decide on 10%, 25%, or 50%, or may use only two discounted tiers.

Keep the system simple enough that staff and patients can understand it.

Step 4: Test the Discount Structure Against Your Practice Finances

Do not adopt a discount schedule just because the percentages look reasonable. Test the patient mix.

Sample Patient Mix Test

Tier → Monthly Price → Annual Price → # Patients → Annual Revenue
Standard → $100 → $1,200 → 400 → $480,000
20% discount → $80 → $960 → 50 → $48,000
40% discount → $60 → $720 → 30 → $21,600
60% discount → $40 → $480 → 20 → $9,600

Total patients: 500
Total projected annual revenue: $559,200

Now compare that with the amount your practice requires. If required annual revenue is $550,000, the model may work. If required annual revenue is $590,000, it does not. Change the number of discounted patients, discount percentages, standard pricing, expenses, or another part of the model before implementation.

Step 5: Set the Maximum You Can Offer

You do not have to offer unlimited discounted care. Pick a limit you can monitor. You can limit the program by:

Ways to Limit the Program

- Number of Patients — Example: Up to 50 reduced-fee memberships.
- Percentage of Panel — Example: Up to 10% of the patient panel.
- Number of Visits — Example: Up to 20 reduced-fee appointments per month.
- Annual Dollar Amount — Example: Up to $25,000 per year in total fee reductions.

Once the Limit Is Reached

Additional qualified patients can be placed on a waiting list once the limit is reached.

Step 6: Set Your Lowest Acceptable Price

Decide the lowest fee before you begin taking applications. A sliding fee scale does not have to include free care. For membership practices, remember that a discounted member may use more care than a full-price member.

For Fee-for-Service Practices, Consider:

- Physician time
- Staff time
- Supplies
- Procedures
- Medications
- Labs
- Outside costs

Services You May Exclude

You do not have to discount every service. You may decide that certain items are excluded, including:

- Vaccines
- Medications
- Lab charges
- Imaging
- Supplies
- Procedures with significant material costs
- Services provided by outside organizations

List those exclusions clearly in your policy.

Step 7: Decide Who Qualifies

A straightforward method is to use:

• Household size
• Household income
• Household income compared with the current HHS Poverty Guidelines

HHS updates the poverty guidelines every year. Use the current guidelines when you create or update your policy.

Calculating a Household's Percentage

Formula: Annual Household Income ÷ Applicable HHS Poverty Guideline × 100

Example: Annual household income $49,500; applicable guideline $33,000.
$49,500 ÷ $33,000 = 1.5

The household income is 150% of the applicable guideline.

Step 8: Define Household and Income

Decide what your practice means by household. You may include:

- Patient
- Spouse or partner
- Dependent children
- Other dependents supported by household income

What Income to Count

Decide what income you will count. Examples may include:

- Wages
- Salary
- Self-employment income
- Social Security
- Pension income
- Disability income
- Unemployment income
- Other regular household income

Decide whether you will use:

- Current gross household income
- Prior-year income
- Adjusted gross income
- Another clearly defined measure

Use the same definition consistently.

Step 9: Decide What Documentation You Require

Possible Documentation

- Recent pay stubs
- Federal tax return
- W-2
- 1099
- Social Security statement
- Disability statement
- Unemployment documentation
- Pension or retirement statement
- Self-employment documentation

When Current Income Differs From the Prior Tax Year

You also need a process for someone whose current income is very different from the previous tax year. Examples include:

- Job loss
- Reduced hours
- Disability
- Divorce or separation
- Major recent income change

Document the exception and the reason.

Step 10: Decide How Long Approval Lasts

Choose a defined approval period. Common options include:
• 6 months
• 12 months
• Until annual membership renewal

Annual renewal is usually the easiest for a membership practice. Also decide whether patients must report a significant change in income or household size during the approval period.

Step 11: Decide What Happens When the Program Is Full

Choose the rule before you need it. Options include:
• Waiting list
• Reapply at the next renewal period
• Open a new spot only when another discounted patient leaves
• Add capacity only when practice finances allow it

Avoid renegotiating the rules patient by patient.

Step 12: Review the Program

Track:
• Number of reduced-fee patients
• Number of patients in each tier
• Percentage of your panel receiving discounts
• Number of reduced-fee visits
• Standard revenue represented by those patients
• Actual revenue collected
• Total annual fee reductions
• Remaining program capacity
• Waiting-list size

Membership Practices

Calculate: Total Membership Revenue ÷ Total Members = Average Annual Revenue per Patient

Compare that number with the amount your financial model requires.

Example: Required average: $1,000 per patient | Actual average: $1,075

The practice is currently above the required average.

If the actual average drops below the required amount, review the number of discounted memberships, pricing, expenses, or another part of the model before adding more reduced-fee patients.

Step 13: Review the Scale Once a Year

Review:

- Current HHS Poverty Guidelines
- Standard pricing
- Discounted pricing
- Practice expenses
- Physician compensation
- Patient or visit capacity
- Number of discounted patients
- Total discounts provided
- Waiting-list demand
- Patient utilization
- Whether your lowest tier is still sustainable

Update the policy when needed.

Medicare, Insurance, and Compliance

Cash practices still need to consider Medicare, Medicaid, commercial payer contracts, state law, and other applicable requirements.

Physicians who have opted out of Medicare and see Medicare beneficiaries must follow Medicare opt-out and private-contract requirements.

Physicians who participate with Medicare or other payers should also be careful about reducing or waiving required patient cost-sharing.

Before using a sliding fee policy for Medicare beneficiaries, Medicaid patients, insured patients, deductibles, coinsurance, or services controlled by payer agreements, have the policy reviewed by a healthcare attorney or qualified compliance professional familiar with your practice model.

Sliding Fee Scale Worksheet

Use this worksheet to build and test your sliding fee scale before you finalize a policy.

Your Standard Pricing

Standard membership price: $_____ or Standard service price: $_____

Services included in the sliding scale:

_____

Services excluded:

_____

Practice Financial Needs

Required annual practice revenue: $_____

Membership Practice — Realistic panel size: _____
Required average annual revenue per patient: $_____ ÷ _____ = $_____

Fee-for-Service Practice — Realistic annual visits: _____
Required annual clinical revenue: $_____
Required average revenue per visit: $_____ ÷ _____ = $_____

Proposed Sliding Scale

Standard price: $_____

Tier 1 — Discount: _____ Price: $_____
Tier 2 — Discount: _____ Price: $_____
Tier 3 — Discount: _____ Price: $_____

Lowest acceptable price: $_____

Program Limit

Choose one or more:

□ Maximum number of reduced-fee patients — Maximum: _____
□ Maximum percentage of patient panel — Maximum: _____
□ Maximum reduced-fee visits — Maximum: _____
□ Annual fee-reduction budget — Maximum: $_____

Membership Revenue Test

Tier → Price → # of Patients → Annual Revenue
Standard → $_____ → _____ → $_____
Tier 1 → $_____ → _____ → $_____
Tier 2 → $_____ → _____ → $_____
Tier 3 → $_____ → _____ → $_____

Total patients: _____
Projected annual revenue: $_____
Required annual revenue: $_____
Difference: $_____

Is this sustainable?
□ Yes □ No

Fee-for-Service Revenue Test

Service → Standard Fee → Reduced Fee → Reduced Visits → Revenue Reduction
_____ → $_____ → $_____ → _____ → $_____
_____ → $_____ → $_____ → _____ → $_____
_____ → $_____ → $_____ → _____ → $_____

Total projected annual revenue reduction: $_____

Can the practice support this amount?
□ Yes □ No

If no, change the number of discounted patients or visits, the amount of the discount, or another part of the financial model.

Sliding Fee Policy Builder

Practice name: _____
Effective date: _____

Eligibility

Patients may qualify for reduced pricing when household income is at or below ____% of the applicable HHS Poverty Guideline.

Household is defined as:

_____

Income is defined as:

_____

Pricing

Standard price: $_____

Tier 1 — Eligibility: _____ Discount: _____ Price: $_____
Tier 2 — Eligibility: _____ Discount: _____ Price: $_____
Tier 3 — Eligibility: _____ Discount: _____ Price: $_____

Program Capacity

(Complete whichever applies to your program.)

Maximum reduced-fee patients: _____
or Maximum percentage of panel: _____
or Maximum reduced-fee visits: _____
or Annual reduced-fee budget: $_____

Sliding Fee Policy Builder (continued)

Services Included:

_____

Services Excluded:

_____

Documentation Required:

_____

Approval Period

Approval lasts: _____

Patients reapply: _____

Changes in Income or Household Size — Patients are required to report:

_____

When Program Capacity Is Full:

_____

Application Approval

Applications are reviewed by: _____

Annual Review

Policy will be reviewed each: _____

Patient Sliding Fee Application

About the Program

Our practice offers a limited amount of reduced-fee care for patients who meet the financial eligibility requirements in our sliding fee policy. Eligibility is based on household size, household income, the practice's established criteria, and availability within the program. Submitting an application does not guarantee approval or availability. Please provide complete and accurate information.

Patient Information

Patient name: _____

Date of birth: _____ Date of application: _____

Address: _____

City / State / ZIP: _____

Phone: _____ Email: _____

Household Information

Number of people in household: _____ Number of dependents: _____

Household Members

Name → Relationship to Patient → Age (if Dependent)

_____ → _____ → _____
_____ → _____ → _____
_____ → _____ → _____
_____ → _____ → _____

Household Income

Household Member → Income Source → Amount → Frequency

_____ → _____ → $_____ → _____
_____ → _____ → $_____ → _____
_____ → _____ → $_____ → _____
_____ → _____ → $_____ → _____

Estimated total annual household income: $_____

Recent Changes in Income

Has your household experienced a significant recent change in income?

□ Yes □ No

If yes, explain: _____

_____

Documentation Submitted

□ Recent pay stubs
□ Federal tax return
□ W-2
□ 1099
□ Social Security statement
□ Disability statement
□ Unemployment documentation
□ Pension or retirement statement
□ Self-employment documentation

Other: _____

Patient Certification

I certify that the information provided in this application is complete and accurate to the best of my knowledge. I understand that the practice may request documentation needed to determine eligibility. I understand that approval is for a limited period and may require renewal. I understand that qualifying financially does not guarantee a reduced-fee membership, appointment, or service if the practice has reached the capacity established for the program.

Patient / Responsible Party Signature: _____ Date: _____
Printed Name: _____

FOR PRACTICE USE ONLY

Application reviewed by: _____ Date: _____

Household size: _____ Annual household income: $_____

Applicable HHS Poverty Guideline: _____ Income as % of guideline: _____%

Decision

□ Standard price
□ Tier 1
□ Tier 2
□ Tier 3
□ Does not qualify
□ Qualifies, but program capacity is full

Approved fee: $_____

Effective date: _____ Expiration date: _____

Notes: _____

_____

Approved by: _____ Date: _____

Sliding Fee Renewal Form

Patient name: _____

Date of birth: _____ Current tier: _____

Current fee: $_____ Current approval expiration date: _____

Household Update

Current household size: _____

Has household size changed?
□ Yes □ No

If yes: _____
_____

Income Update

Current estimated annual household income: $_____

Has household income changed significantly?
□ Yes □ No

If yes: _____
_____

Updated Documentation

□ Recent pay stubs
□ Federal tax return
□ W-2
□ 1099
□ Social Security statement
□ Disability statement
□ Unemployment documentation
□ Pension or retirement statement
□ Self-employment documentation

Other: _____

Patient Certification

I certify that the information provided in this renewal application is complete and accurate to the best of my knowledge.
Patient / Responsible Party Signature: _____

Printed Name: _____ Date: _____

FOR PRACTICE USE ONLY

Updated household size: _____ Updated annual household income: $_____

Applicable HHS Poverty Guideline: _____ Income as % of guideline: _____%

Renewal Decision

□ Continue current tier
□ Move to Tier 1
□ Move to Tier 2
□ Move to Tier 3
□ Return to standard pricing
□ No longer qualifies
□ Qualifies, but program capacity is unavailable

Approved fee: $_____

New effective date: _____ New expiration date: _____

Reviewed by: _____ Date: _____

A Reminder Before You Set Your Scale

A sliding fee scale is not a discount offered out of guilt — it is a pricing tool, calibrated to your own numbers, that lets you extend care to patients who could not otherwise afford it without threatening the financial health of your practice. Build it deliberately, document it clearly, and review it every year.

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