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**NACHC ANALYSIS:**

Establishing and Collecting Fees for Health Center Services

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# **Establishing and Collecting Fees for Health Center Services**

## ***Introduction***

One of the most important and challenging decisions every health center must make is the setting of an appropriate schedule of fees for its services and a corresponding schedule of discounts off fees that are required to be made available to eligible patients. Although there is no generally applicable “formula” for setting fees, there are statutory and regulatory requirements that all health centers must follow in establishing their fee schedules. Within these parameters, a health center must be able to realize revenue from its activities sufficient to remain financially viable while maintaining patient access to services without regard to any patient’s insurance status or ability to pay.

Complicating matters, many health center patients are covered by government-sponsored health plans, such as Medicaid and Medicare. Typically a small number are covered by private insurance plans. These plans invariably have a schedule of fees or reimbursement rates that they will pay a health center for the services, which will not necessarily correspond to the health center’s schedule of charges. The relationship between the billing and collection policies and procedures mandated by Section 330 of the Public Health Service Act (and the implementing regulations) and the obligations that a health center has as a participating provider in a government-sponsored or private health plan are not well understood. But the consequences of failing to apply Section 330 principles can have severe consequences, including grant costs disallowances and other sanctions.

This Analysis by NACHC is intended to clarify Section 330-required billing and collection requirements generally, with specific attention to issues that health centers frequently encounter in contracting with third party payors.

## ***Legal Requirements***

### **Establishing a Fee Schedule and Schedule of Discounts**

#### **1. The Statute**

Section 330(k)(3)(G) of the Public Health Service Act, 42 U.S.C. § 254b, requires a health center to prepare:

- (i) ... a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and ... a corresponding schedule of discounts to be applied to the

payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay....<sup>1</sup>

## 2. The Regulations

The regulations implementing the foregoing provision of Section 330 provide, in pertinent part, that a health center must:

[h]ave prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable cost of operation<sup>2</sup> and a corresponding schedule of discounts adjusted on the basis of the patient's ability to pay. *Provided*, that such schedule of discounts shall provide for a full discount to individuals and families with incomes at or below those set forth in the most recent [federal poverty income guidelines] and for no discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines, except that nominal fees for services may be collected from individuals with incomes at or below such levels where imposition of such fee is consistent with project goals.

42 C.F.R. § 51c.303(f).

### Collecting Fees from Patients and Third Party Payors

Section 330 imposes certain requirements on health centers with respect to the collection of fees and payments. Specifically, Section 330(k)(3)(G) (ii) requires a health center "to make every reasonable effort":

to secure from patients payment for services in accordance with [the fee schedule and schedule of discounts that it has established]; and

to collect reimbursement for health services to persons [covered by Medicare, Medicaid, any other public assistance program, or private health insurance] on the basis of the full amount of fees and payments for such services without application of any discount.

According to the Bureau of Primary Health Care (BPHC) health center program expectations, a health center's billing and collection policies must be designed to assure patient access to care while maximizing revenue collected from all non-federal, that is, non-Section 330 grant, sources. In particular, Section 330 requires that no discount off of the full amount of fees and payments (as determined in accordance with the principles set forth in Section 330 and the implementing regulations) be provided to Medicare, Medicaid, any other public assistance program or private

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<sup>1</sup> Compliance with this requirement technically is a condition to receiving grant funds under Section 330 but is applicable to all federally qualified health centers whether or not they receive Section 330 grant funds. *See* 42 U.S.C. § 1396d(1)(2)(B).

<sup>2</sup> These regulations date from 1976 and do not reflect the "consistent with prevailing charges" requirement that was later added to Section 330. In this regard, the statute governs.

health insurers. Further, the mandate to assure access while maximizing revenue extends to fees charged at discounted levels to uninsured or underinsured<sup>3</sup> patients with incomes at or below 200% of the poverty level. See BPHC Policy Information Notice 98-23, *Health Center Program Expectations*, at p. 37. For example, if relatively few patients with incomes at 150% of the federal poverty income guidelines are accessing or paying for a primary care visit that is discounted 50% (or accessing primary care at all), a health center may need to consider whether the pattern of nonpayment or under-utilization is due to patients at that income level being unable to pay the discounted charge. In such instance, the health center may need to revise its schedule of discounts to increase the discount in order to assure patient access, while still generating a level of revenue from the visit that uninsured and underinsured patients at that income level can reasonably afford to pay.

In short, Section 330 and the implementing regulations contemplate that a health center will follow a three-step process in establishing a schedule of fees or payments for its services:

- a. the fees or payments must be set so as to cover the health center's reasonable costs in providing the service;
- b. the fees or payments must be consistent with locally prevailing rates or charges for the service; and
- c. there must be a corresponding schedule of discounts applied to the fees or payments for uninsured and underinsured persons whose incomes are at or below 200% of the then current federal poverty income guidelines, which discounts must be adjusted on the basis of each patient's ability to pay.

Accordingly, under the regulations: (1) health centers must charge patients with annual incomes above 200% of the poverty income guidelines, as well as third party payors without applying any discount off fees or payments; (2) discounts must be applied to charges to ensure access for uninsured and underinsured patients with annual incomes between 100% and 200 % of the poverty income guidelines; and (3) health centers may collect, at most, nominal fees from uninsured and underinsured patients with incomes at or below 100% of the poverty income guidelines.

Note that the term "nominal fee" is not defined in Section 330 or the regulations. Moreover, neither federal regulations nor BPHC policy statements dictate how a health center is to establish its schedule of discounts. Each health center has substantial discretion regarding the levels of discounts offered to uninsured and underinsured patients with incomes between 100% and 200% of the poverty income guidelines. Equally important, there is no requirement that a patient whose income is between 100% and 200% of the federal poverty level receive the same discount for each and every service provided. For example, a patient whose income is at 150% of the poverty guidelines could be given a 30% discount on one service and a 60% discount on another service. Nor must the discount methodology be percentage based. A health center's schedule of

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<sup>3</sup> "Underinsured," for this purpose, includes instances where a patient's coverage has been exhausted, where the patient's insurance does not cover the particular service rendered, and where the insurance does not cover the total cost of services as in the case of a patient co-payment requirement.

discounts could provide specific dollar amounts to be paid for services based on the patient's ability to pay.

As the language of the statute makes clear, the fees for services must be set with reference to the center's *costs* in providing the services and the prevailing charges or rates for the services in the community. Thus, a health center's schedule of fees is not intended to be the mechanism for addressing access to primary care for low-income uninsured and underinsured populations. Rather, the schedule of charges is the vehicle by which the health center is expected to maximize revenues from third party payors and patients with higher incomes (so that Section 330 grant funds are used for their intended purpose of subsidizing the cost of providing services to lower income uninsured or underinsured persons). Access to care is addressed through the schedule of discounts that is applied to the fees or payments, which discounts are based on an uninsured or underinsured patient's ability to pay (with reference to the federal poverty income guidelines).

### ***Applying Section 330 Requirements in Practice***

#### **Determining the Cost of Services Provided and Locally Prevailing Charges**

It is critical that a health center determine its actual cost of providing a service. As noted above, a health center's "reasonable costs of operation" is the foundation for establishing a fee schedule in accordance with Section 330 requirements. Moreover, from a business perspective, a health center must know what its cost of providing services actually is in order to rationally budget and manage within budget. A discussion of techniques for determining costs of services is beyond the scope of this Analysis. However, there are numerous NACHC publications and training programs that address cost determination techniques.

Having determined its cost of providing a service, a health center also must consider "locally prevailing charges" in setting a fee schedule. This necessarily requires a comparison to charges for comparable services rendered by other health care providers in the community. As few, if any, providers provide the comprehensive range of services required of a health center, including, for example, translation or transportation services, this comparison should be made with reference to commonly used service definitions, such as CPT codes. Note that an "all inclusive" or PPS rate used for Medicaid reimbursement is not likely to be a good basis of comparison, as such rates are likewise based on the unique scope of health center services.

#### **Private Health Insurance**

As noted, Section 330 requires health centers to make "every reasonable effort" to collect reimbursement for services provided to persons covered by private health insurance "on the basis of the full amount of fees and payments for such services without application of any discount." In short, a health center may not apply the schedule of discounts to fees charged to patients with private health insurance. Privately insured patients should be billed and/or claims submitted to insurance plans according to the health center's established fee schedule for the services rendered.

Taken literally, Section 330's prohibition against discounting fees charged insurers would mean that a health center could not contract with a third party private payor to accept reimbursement less than its fees for the service. However, as a practical matter, private insurers typically establish the reimbursement rate for a particular service (often with little room for negotiation). Indeed, the locally prevailing rates or charges in a community for a particular service may well be the payment rate which private insurers are willing to pay for the service.

Accordingly, in NACHC's view, a health center may accept a reimbursement rate from a private health plan for a particular service that is less than its established fees for the service, **provided that the rate is consistent with what the insurer pays other providers for that service in the community and, most importantly, provided that the reimbursement is sufficient to cover the health center's reasonable cost of providing the service.**<sup>4</sup> Accepting less would be inconsistent with the "every reasonable effort" to collect full payment mandated by Section 330. In that regard, health centers should keep in mind that health center grant budgets are determined, in part, based on projected income from third party payors. Given the unequivocal language in the statute, health centers, by implication, assert that their contract and other arrangements with third party payors do not provide them with impermissible discounts, but rather reflect locally prevailing rates or charges and cover the health center's costs. If the projections assume discounts offered to payors (below locally prevailing charges or rates), a health center that uses Section 330 funds to make up the shortfall is opening itself to a potential cost disallowance. In sum, Section 330 grant funds are not intended to, in effect, subsidize third party payors.

Further, contracting for reimbursement at less than the cost of providing a service has implications beyond Section 330 requirements. A charitable organization, such as a health center, that allows its resources to unreasonably benefit a private party, such as an insurer, may jeopardize its federal income tax exemption. Additionally, such a "discount" could implicate the federal anti-kickback statute, which can result in criminal sanctions for both parties to the transaction.

Other important points to consider when contracting with private insurers:

1. Typically, a private health insurer contracts with a provider for a range of health care services that the insurer has agreed to provide to its policy holders or enrolled members. As previously noted, this scope of services is likely to be much narrower than the scope of services that a health center typically provides (and that it is legally required to provide as a federally qualified health center). A health center's costs in providing services to a patient under the patient's private insurance (which typically does not include the full range of FQHC services) are likely to be reduced accordingly. Thus, a health center may be able to determine that the reimbursement provided under a private insurance contract indeed covers its costs of providing the contracted services, consistent with Section 330 requirements. This further underscores the

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<sup>4</sup> HRSA has never, to our knowledge, indicated otherwise in policy statements or enforcement actions.

importance of a health center determining its actual costs for providing its various health care services.<sup>5</sup>

2. While a health center is required to contract or have other arrangements (or to make every reasonable effort to do so) with the state in which it operates to provide services to Medicaid and Children's Health Insurance Program ("CHIP") beneficiaries (*see* 42 U.S.C. § 254b(k)(3)(E)), it is not required to contract with private insurance plans. Therefore, a health center has no legal obligation to participate in a health plan that does not offer the health center adequate reimbursement for the services provided to patients covered by the plan, and should feel free to reject arrangements that do not offer adequate reimbursement. In some situations a health center may feel pressure to accept less than favorable insurance reimbursement rates in order to fulfill its mission of offering services to all residents of its medically underserved community or a special population. This might occur, for example, in a community where the health center is the only available primary care provider (or one of just a few primary care providers) and there is a significant patient population with private health insurance. On the other hand, these circumstances may well put the health center in a better bargaining position with the insurers because they need health care providers to fulfill their obligation to their enrollees. In other instances, health centers report that they feel forced to accept lower rates (albeit consistent with the rates the insurer pays others in the community) so as to be competitive where significant numbers of individuals and families in the community are privately insured. Regardless of the rationale, the health center must be sure its costs are covered.

3. Reimbursement provisions of provider contracts and participation agreements for private health plans are binding on a health center (provided, of course, that the terms are unambiguous and set out in a legally enforceable agreement). A health center should fully understand the reimbursement provisions (and their financial implications for the health center) *before* signing or otherwise indicating its acceptance of the terms (such as by submitting claims to the insurance carrier). In particular, a health center should be alert to contract provisions that define reimbursement in terms of charges for services provided to "cash paying" patients or that require a health center to provide its "best price" to an insurer. Such provisions could effectively require the health center to pass on the discounts provided to uninsured patients under the center's schedule of discounts to the insurer. As previously noted, this practice would be inconsistent with Section 330, which prohibits passing on discounts to health plans. In addition, a health center should not agree to accept unilateral amendments or addenda to any contract or agreement (which frequently are used to modify reimbursement rates) without completely understanding its terms and any consequences for the health center. In sum, due diligence in contracting with private health plans is essential.

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<sup>5</sup> An accurate determination of a health center's actual costs is, of course, critical, often requiring relatively sophisticated analysis. For example, a reimbursement rate that adequately covers a health center's fixed costs may be more advantageous than one that provides a better rate for the health center's variable costs.

## Government-Sponsored Health Programs

Section 330 contains several provisions regarding a health center's participation in government-sponsored health benefit programs. As noted, the statute requires health centers to participate in (or to make every reasonable effort to participate in) state Medicaid and CHIP programs. The statute further provides that a health center contract or other arrangement with a state Medicaid agency provide "for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under the State [Medicaid] plan."<sup>6</sup> See 42 U.S.C. § 254b(k)(3)(E)(i)(I). In this regard, a health center that participates in Medicaid, Medicare, and any other such government health program is required to make "every reasonable effort" to collect "appropriate reimbursement for its costs" in providing health services to persons who are entitled to health benefits under such programs. See 42 U.S.C. § 254b(k)(3)(F). As previously stated, health centers are required to collect reimbursement for services provided to persons entitled to benefits under those programs (and, as noted above, persons covered by private health plans) "on the basis of the full amount of fees and payments for such services without application of any discount." See 42 U.S.C. § 254b(k)(3)(G)(ii)(II).

As with private health insurance, Section 330 provides that health centers are not to give "discounts" to government-sponsored health plans. However, as a practical matter, health centers have virtually no room to negotiate individual payment rates with government-sponsored health plans as those typically are set by legislation or a government administrative agency. Federally qualified health centers enjoy some protection in this regard because of the favorable payment rates mandated by federal law for Medicare and Medicaid services, although state Medicaid agencies, and the Centers for Medicare and Medicaid Services, may not necessarily fully honor those requirements. Health centers, individually or collectively, may have to advocate for legislative or administrative change, or even litigate to address inadequate payment rates.<sup>7</sup>

There is an increasing number of health care programs sponsored by state and local governments that are designed to make health care available to otherwise uninsured persons, such as persons who are not eligible for Medicaid. Health centers should be cautious when participating in such programs. These programs may well provide health centers with revenue that they would not otherwise have, but the Section 330 requirements regarding charges, discounts, and maximizing revenue continue to apply. For example, Section 330 does not authorize a health center to discount charges for services to patients with incomes over 200% of the federal poverty income guidelines. Some state and local indigent care programs cover persons with incomes up to 250% or more of the poverty income guidelines. In such cases, in order to comply with Section 330 requirements, a health center should not accept less than its full fees (as established pursuant to Section 330 principles) for persons with income over 200% of the federal poverty income guidelines. As previously noted, federal grant funds cannot be used to cover the shortfall as

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<sup>6</sup> There is no similar cost recovery provision with regard to CHIP contracts or arrangements.

<sup>7</sup> Because Medicaid and Medicare payment methodology for federally qualified health centers is so intertwined with government regulation and public policy, it is unlikely that a health center could be faulted, from a Section 330 compliance perspective, for accepting Medicaid and Medicare payment rates that may not fully cover its costs.

Section 330 funds are to be used exclusively to support services for persons at or below 200% of the poverty income guidelines.

### Billing and Collecting Reimbursement for Pharmacy Services

With the enactment of Section 340B of the Public Health Service Act in 1992, 42 U.S.C. § 256b, some health centers have been able to implement pharmacy service programs for the first time; others have been able to expand existing services. Wider use of the contract pharmacy model for dispensing outpatient pharmaceuticals and creative projects established under Alternative Methods Demonstration Projects approved by HRSA's Office of Pharmacy Affairs have increased the visibility of, and interest in, the 340B program. Nevertheless, even with the substantial discounts off acquisition costs of outpatient pharmaceuticals available to health centers participating in the 340B program, operating a fiscally viable health center pharmacy is challenging, given the increasing cost of pharmaceuticals and the rising number of low-income uninsured and underinsured persons accessing these services.

Of concern, the significant cost savings for pharmaceuticals acquired under 340B pricing and the expansion of health center pharmacy programs utilizing 340B drugs sometimes obscure the relationship between 340B pricing and the fee schedule and discount structure for health center services established under Section 330 and implementing regulations. It is critical that health centers keep the following key principles in mind, and act accordingly, in implementing and operating a pharmacy program utilizing Section 340B pricing.

#### **The Section 330 requirements (discussed above) for establishing fees and discount schedules apply to a health center's pharmacy services.<sup>8</sup>**

Pharmaceutical services, "as appropriate" for a particular health center, are a required primary care service. *See* 42 U.S.C. § 254b(b)(1)(A)(i)(V). While the "as appropriate" language in the statute appears to provide health centers with some flexibility regarding the type and intensity of the pharmaceutical services that they provide, NACHC is not aware of HRSA having interpreted that provision of the statute to permit health centers, with respect to pharmaceutical services (whether acquired under the 340B program or not), to disregard the provisions of Section 330 and the implementing regulations that direct how a health center is to establish and apply its schedule of fees and corresponding schedule of discounts.

A health center that participates in the Section 340B discount program will enjoy significant savings when procuring outpatient drugs. However, while Section 340B governs the *price* that a health center (and other covered entities) pays for a covered drug, with one notable exception,<sup>9</sup>

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<sup>8</sup> For a comprehensive discussion of fee schedules for pharmacy services, see NACHC Issue Brief #22, *Setting the Fee Schedules for Health Center Services*, August 2003.

<sup>9</sup> According to several DHHS-published notices and guidances, ( see, for example, 58 Fed. Reg. 34,058(6/23/93) health centers (and other covered entities) may bill a state Medicaid agency for a drug acquired at 340B pricing only at the acquisition cost of the drug plus a "reasonable" dispensing fee allowed by the Medicaid agency when the reimbursement is on a fee-for-service basis. This policy is intended to ensure that the Medicaid agency obtains the equivalent of the full manufacturer rebate that it would have received had the drug not been acquired under 340B prices. This limitation on billing Medicaid does not apply when a health center (or other covered entity) dispenses a

Section 340B is entirely silent on what a health center should *charge* patients and third party payors. For health centers, establishing fees and discounts for pharmaceutical services, including utilizing drugs acquired at 340B pricing, is governed by Section 330 and the related regulations.

**Section 340B is intended to benefit health centers (and other covered entities) that procure outpatient drugs for their patients.**

The 340B program is designed to make it more feasible for a health center to establish and operate a viable pharmacy program, and, in particular, to relieve a portion of the financial burden of serving low-income, uninsured and underinsured patients whose care must be heavily subsidized in accordance with Section 330 principles. In that regard, the 340B program should not be viewed *per se* as a drug discount program for patients. Rather, it is a “benefit” that a health center can utilize to enable it to make pharmaceuticals accessible to all of its patients regardless of each patient’s ability to pay or insurance status.

These principles have profound implications for a health center’s pharmacy program.

1 Fees for outpatient drugs, including drugs acquired at 340B pricing, should be set at or close to the prevailing rate or charge in the community for the drug in order to comply with Section 330 requirements. Given the deep discount on the health center’s acquisition cost available under the 340B program,<sup>10</sup> a health center should have little difficulty in covering its cost of acquiring the drug and the associated costs of administering the pharmacy program (including dispensing fees and allocable overhead) in setting fees for each drug at the prevailing community rate. Indeed, the margin between a health center’s costs and its charges for the drug can and should be used to support the cost of providing pharmacy services to patients who are entitled to a discount, namely, uninsured and underinsured persons with income at or below 200% of the federal poverty guidelines. *See* 61 *Fed. Reg.* 43551 (August 23, 1996)

In contrast, a pharmacy fee schedule that simply passes on the health center’s acquisition costs for a drug (plus, presumably, a dispensing or administrative fee) is not consistent with Section 330 requirements in two respects: (1) with regard to the fee structure itself, and (2) insofar as it provides a discount off of locally prevailing rates to patients who are not entitled to a discount, *i.e.*, patients who are insured or are beneficiaries of a health program and uninsured or underinsured patients with annual incomes exceeding 200% of the poverty guidelines. Moreover, this approach fails to maximize a health center’s revenue, as required by Section 330 regulations. *See* 42 C.F.R. § 51c.303(f).

It should be noted that Section 330 requires that fees be set “consistent with” the locally prevailing rate for a service, which does not necessarily mean “equal to” the prevailing rate. In NACHC’s view, “consistent with” implies that a health center has some degree of flexibility in

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drug that was not acquired under 340B pricing, *i.e.*, the health center “carves out” Medicaid purchases from its 340B purchases, nor to reimbursement under an all-inclusive rate in a Medicaid managed care arrangement.

<sup>10</sup> In some cases, health centers may be able to acquire drugs at less than the applicable 340B price. As previously noted, the 340B program does not dictate (except with regard to fee-for-service Medicaid) what a health center may charge for a drug. In that regard, the fact that a drug is purchased under 340B pricing is irrelevant to a health center’s fees for the drug.

establishing fees for pharmacy services, *i.e.* if a health center were to set its fees slightly below the prevailing community rate to encourage persons above 200% of the federal poverty income guidelines to use the health center's pharmacy. As noted above, this should generate income for the center that can help defray the cost of providing pharmacy services to persons eligible for a discount, *i.e.*, uninsured and underinsured persons with incomes at or below 200% of the federal poverty guidelines.

2. A health center's schedule of discounts must be applied to fees for pharmacy services. In particular, the Section 330 regulations require a "full discount" or only a "nominal" charge for uninsured and underinsured persons with income at or below 100% of the federal poverty income guidelines. Moreover, while the cost of a service is a factor in determining a health center's fee for the service (as the fee must be designed to cover the health center's reasonable costs in providing the services), the health center's schedule of discounts must be based on an uninsured and underinsured patient's ability to pay. Health centers sometimes set the fee for 340B pharmaceuticals dispensed to persons eligible for a full discount, *i.e.*, with income at or below 100% of the federal poverty income guidelines, at the health center's cost of procuring the drug, perhaps with a modest markup for a dispensing fee. They reason that the 340B discount price allows the center to cover its costs and that the final fee charged to the patient, even with a dispensing fee included, is likely to be significantly less than the patient would pay elsewhere. This practice, however, is not consistent with Section 330 requirements because, while a "discount" is being passed on to the patient, it is not based on an uninsured or underinsured patient's ability to pay. For example, an uninsured or underinsured patient with income at or below 100% of the federal poverty guidelines may not be able to afford even the 340B price of an expensive drug. In short, charging more than a "nominal" fee for pharmacy services (which nominal fee may well be less than the health center's cost in procuring the drug and dispensing it) to persons entitled to a full discount under Section 330 may present an insurmountable barrier to the person's ability to access needed pharmaceuticals.

As previously noted, health centers have substantial flexibility in establishing their schedule of discounts. Discounts need not be the same across the board for all health center services. Thus, the schedule of discounts for pharmacy services need not be identical to the discount schedule for other services. (Of course, any discount should be available equally to all uninsured and underinsured persons at the same income level.) Similarly, a health center may provide deeper discounts on more expensive drugs and smaller discounts on the less costly, more affordable drugs if doing so does not create an access barrier.

3. A health center should be extremely cautious when dispensing drugs acquired at 340B prices in connection with its participation in, or contract with, private insurance or health plans. Specifically, a health center that agrees to "share savings" with private insurers by accepting less than what the insurer pays to other pharmacies in the community is not operating in accordance with Section 330 requirements. The comparatively inexpensive cost of drugs acquired under 340B should not obscure the fact that Section 330 requires that charges to private health insurers for pharmaceutical services be set at the prevailing rate in the community (subject to the minor adjustments discussed above) without provision of any discount to the insurer. Accordingly, health centers should vigorously resist any effort by a private insurer to divert the benefit of the 340B program to itself by offering the health center below-market payment rates.

As noted previously, the “prevailing rate” in the community for pharmaceutical reimbursement may well be established by what private insurers and health plans with a significant enrollment in the community are willing to pay for those services. Therefore, health centers should seek payment from private insurers of at least the same rate as is generally paid to commercial pharmacies in the community (making certain, of course, that the health center’s payment rate covers its costs of providing the pharmaceutical service). In short, the fact that a health center is able to acquire drugs at 340B prices should be irrelevant to the amount of payment that it receives from private health plans.

Finally, drug pricing and the methodology that private insurers use to pay for pharmaceutical services (which often takes into account the pharmacy’s cost of ingredients) is extremely complex. It is, therefore, immensely important to carefully review and to fully understand contractual payment provisions and to seek payment in accordance with the terms of the health center’s participation agreement.

### *Conclusion*

Setting fees for services requires a health center to address complex economic issues, including its costs of providing services and its patients’ ability to pay for those services all in the context of a statutory and regulatory scheme that requires that a health center include certain features in its schedule of fees and corresponding schedule of discounts. Nevertheless, health centers have considerable flexibility, within those parameters, to develop an appropriate fee/discount policy.

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