NATIONAL HEALTH CARE for the HOMELESS COUNCIL

September 11, 2012

James Macrae
Associate Administrator
Health Services and Resources Administration
5600 Fishers Lane
Rockville, MD 20857

RE: Comments to Draft HRSA PIN on Sliding Fee Scale

Dear Mr. Macrae:

The National HCH Council appreciates the opportunity to comment formally on the Draft HRSA Policy Information Notice regarding Clarification of Sliding Fee Discount Program Requirements. We welcome the consolidation of previous guidances and the numerous clarifications throughout the document.

This PIN provides a welcome and critical opportunity to *guarantee* that that no patient is denied care due to an inability to pay. We observe with regret that the PIN as drafted does not fully accomplish that purpose, which is central to the mission of the Health Center Program.

Our members have frequently noted that inability to pay Health Center charges has prohibited our impoverished clients from receiving needed care on referral. Based on our experience, we believe that *any* fee charged to people experiencing homelessness or to people earning below 100% FPL is a very significant barrier to care.

Moreover, at least in the case of stand-alone HCH grantees, the infrastructure costs of attempting to collect cash fees from patients with no apparent resources may far outweigh any possible return on investment.

With this in mind, we submit the following comments and recommendations for your consideration:

1. **Do not compromise the concept of "full discount" by allowing for an ill-defined "nominal fee."** There are numerous references throughout the draft PIN to providing a "full discount," yet the statute and the draft PIN also *allow* collection of a "nominal" charge from all patients. We interpret "full discount" to mean 100% discount or a fee

of $0; this should be explicitly stated in the PIN. We hope that the final PIN will *require* health centers to slide their scale to $0 for those patients under 100% FPL (rather than say "are not expected to" p. 6), and that it will not allow imposition of charges that defeat the purpose of the discount.

For someone who has no money, a charge of any size is an obvious barrier to care, whether it is called nominal or not. "Nominal" is defined in the draft as "a fixed, small fee that does not reflect the true value of a service provided and is generally considered to be of token value" (p. 11); however, *we believe these terms are vague, highly subjective, and unresponsive to the needs of patients who literally have nothing.*

We take issue with the assertion that the nominal charge "allows patients to participate in supporting the cost of services and may also serve to prevent inappropriate utilization of services (p.11)." The intent of Section 330 clearly is to facilitate access to health care for the most vulnerable; however, the wording in the draft PIN seems to imply that that if they do not pay money, patients are not participating in their care and may even use care inappropriately. People experiencing homelessness often forgo meals or shelter in order to attend health care appointments; these are sacrifices as significant as any cash payment, and demonstrate the great importance of health care to our patients. Health Center clients often participate quite actively in their care, through patient self-management goal-setting and other evidence-based practices. We believe it is inaccurate and improper to portray patient participation solely in terms of financial ability to pay a fee, however "nominal."

2. **Allow grantees to slide fees to $0 for patients 100-200% FPL:** The draft says that a *partial* discount is *required* for patients between 100-200% FPL (pp. 5, 6, 10, and 11) and requires the SFDS to be established by the governing Board (pp. 8, 9, and 12), with a suggestion of three tiers of fees depending on income levels (p. 10). As fees may be significant barriers to care at these income levels, the PIN should allow Boards to provide a *full* discount at their discretion.

3. **Incorporate the ACA requirement for free preventive care services into Fee Schedules:** Section 2713 of the ACA requires health plans to provide preventive health services with no cost-sharing requirements. This includes 16 services for adults, 22 services for women, and 27 services for children.[1] We believe the SFDS is clearly a cost-sharing mechanism, by design and definition provided on page 11. The PIN should require that fees be set at zero for these preventive services.

4. **Clarify whether SFDS applies to subcontractors that are not sub-recipients** (p. 3 & 13)**:** Many HCH grantees deliver some or all required services through subcontracting arrangements. Some of these subcontractors may meet sub-recipient requirements, but many do not. The PIN makes no reference to HRSA's expectations regarding fee collection for primary care services provided in subcontractor settings. We

[1] A full list of preventive services is available at: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

recommend that subcontractors be treated in the same manner as referral providers in Section VI.E.

5. **Recognize that SFDS procedures and especially fee collection are inappropriate and/or cost inefficient at some sites:** The final PIN should acknowledge that not all health center delivery sites are appropriate locations for these procedures, and should explicitly relieve such sites from these requirements. HCH grantees routinely deliver services within homeless shelters, on the streets, and in other non-traditional venues where questions about income or assessment of an out-of-pocket charge are not welcome or appropriate, and would serve as a serious barrier to care. Numerous HCH settings are also not safe places for either our patients or our providers to handle cash transactions, as the environs are typically not secure and our providers are often working alone, without administrative support. SFDS procedures and collections can be safely implemented at other sites, such as traditional health clinic buildings, but should not be required at inappropriate or unsafe sites.

   Likewise, it is likely that cost-benefit analyses would be badly unfavorable for numerous sites where client payments will be minimal at best. Costs including staff time, lost productivity, systems establishment and maintenance, and security will far outweigh proceeds from client fees. On a site-by-site and/or a population-by-population basis, grantees that can demonstrate an unfavorable cost-benefit ratio should be allowed to forgo fee collections.

   For sites that are (1) inappropriate or unsafe or (2) cost-inefficient for fee collections, we recommend that the annual updating of Form 5-Part B (listing of sites) simply allow the grantee to indicate whether or not fees will be collected at each site. In addition to physical sites, the Scope of Project PIN (2008-01) establishes a set of Other Activities [Section B.1.(g)]; grantees engaged in these activities should be allowed to opt out of fee collection by the same check-off mechanism as for sites.

6. **Require facilitation of health insurance applications:** The draft guidance indicates that "health centers must first evaluate a patient's existing coverage or eligibility for coverage under public and private third party payors before assessing their eligibility for the SFDS" (pp. 9, 14). Given the vastly simplified enrollment procedures for Medicaid and the state health insurance exchanges that CMS has issued, it is reasonable to require that health centers not only *assess* for eligibility, *but also to facilitate enrollment of eligible patients* through means that will vary, depending on State-level ACA implementation decisions and local resources. Health Centers should be required to document collaboration with State Medicaid and Health Insurance Exchanges for this purpose. The PIN should encourage approaches such as out stationing state enrollment workers at grantee sites and point-of-service on-line real time application submission.

7. **Clarify what constitutes "reasonable efforts" to collect fees and eliminate the possibility that services will be denied for non-payment.** The draft PIN allows Boards to set terms under which, as a last resort, patients will be "discharged" from

services for refusal to pay (p. 17). In practice, it is often quite difficult to distinguish "refusal" from "inability" to pay. While we are painfully aware of circumstances when it is necessary to bar certain patients from service sites (typically for safety reasons related to behavioral issues), "discharge" for reasons of non-payment is entirely contrary to the access mission of health centers. "

"Reasonable efforts" to collect are not defined in the draft PIN; we recommend that HRSA provide a definition that

- excludes denial of services on account of unpaid past fees, and
- clarifies that an unfavorable cost-benefit ratio makes a fee-collection effort unreasonable.

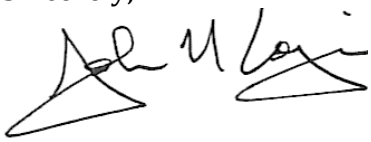
8. **Address conflict with state law.** In some cases, Health Centers are subject to state law that is contrary to the federal policy enunciated in the draft PIN. For Health Centers affiliated with hospitals, California Health and Safety Code [Chapter 2 of Division 107 Article 3, Hospital Fair Pricing Policies, Section 127405] requires a discount policy that provides discounts for up to 350% of FPL, or more. This conflicts directly with the Section 330 requirement of NO discount for anyone over 200% of FPL. As this is a direct conflict in the law, it may not be resolvable in a PIN, but the incompatibility should be acknowledged and affected Health Centers should somehow be protected from adverse consequences.

We do not find in the draft PIN any reference to current Health Center practices regarding fee collection, or to their effect on health center patients and potential patients, or to the research on care-seeking behavior that should effect decisions about nominal fees. We acknowledge that our own recommendations are based not on rigorous research, but on years of observations in the HCH field. We encourage HRSA to develop this data in order to inform any future revision of this policy, and would be pleased to collaborate in any necessary research.

However, we strongly recommend that the draft be amended as we suggest above, and be issued forthwith.

Thank you for your work on this PIN and for your abiding concern regarding the issues addressed here. Should you wish to discuss these or other concerns, please contact me at 615-226-2292 or at jlozier@nhchc.org.

Sincerely,



John N. Lozier, MSSW
Executive Director