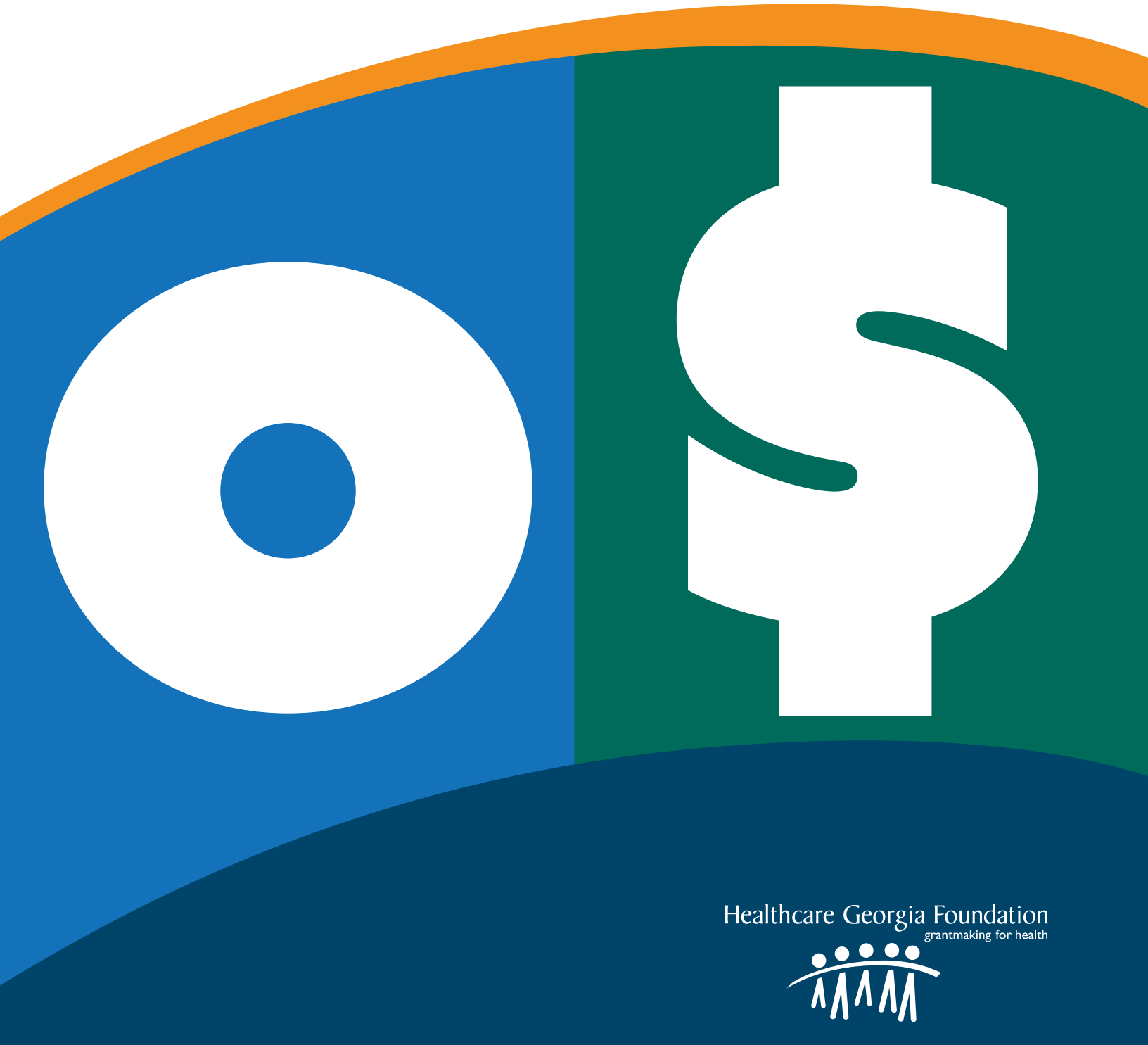
Free or Fee-Based?

Issues to Consider for Georgia's Charitable Clinics



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I. Introduction

The advent of the Affordable Care Act and access to more affordable health insurance options for low-income individuals are forcing volunteer-driven, community-supported safety net clinics across the nation to re-examine their business models. Georgia's charitable clinic sector is no exception. Amidst a rapidly changing healthcare environment where sustainability, value, patient-centeredness, and health improvement are increasingly important, charitable clinic leaders must look for ways to keep their organizations relevant and viable. Despite continuing misperceptions that healthcare reform reduces the need for safety net providers, many charitable clinics today actually face increasing demand for their services yet downward pressure on their sources of funding and support. As a result, a number of Georgia's charitable clinics—most of which have been completely free to patients up until now—are beginning to consider the implementation of patient fees. The purpose of this paper is to shine a light on this emerging development and to provide practical information and guidance for clinic decision-makers.

The topic of whether and how charitable clinics that have been free should consider converting to a fee-based model was one of the featured breakout sessions facilitated by the author at a conference sponsored by the Georgia Charitable Care Network on July 26, 2013, entitled *Safety Net Innovations: Future Business Model Options for Free and Charitable Clinics*. This particular session received high marks from attendees, and the heightened interest in the topic prompted the Healthcare Georgia Foundation to commission this paper in the succeeding months. We wish to acknowledge Donna Looper, Executive Director of Georgia Charitable Care Network, for her assistance in compiling portions of the content and reviewing the final manuscript.

II. National Trend

Over the past decade we have witnessed across the nation a growing number of instances of free clinics converting to fee-based "charitable" clinics. For many sector observers, the label "charitable clinic" refers to a clinic that in every other way looks and acts like a free clinic (i.e., not-for-profit, community-supported, volunteer-driven, predominantly serves the uninsured, etc.) except that it is not free. In addition to free clinic *conversions* to a fee-based model, we have seen an increase in the number of clinics organizing and operating from the outset with a fee structure. There are a number of factors driving the move away from free. Some believe that it creates the wrong impression that a clinic is not only free to the patients but also free to the community, which detracts from fund-raising. Others see in "free" a negative connotation for the clientele served, perceiving that the clinic is a handout (not a hand-up) to a population that feels it is entitled to the services and takes no responsibility for their health or having the resources to pay for it.

In recognition of the trend toward more charitable clinics, a number of associations have elected to brand or re-brand themselves, in some cases eschewing any mention of free clinics. For example, clinic leaders in Texas organized and chose to name their association the Lone Star Association of Charitable Clinics. There is the Oklahoma Charitable Clinic Association. In recent years the National Association of Free Clinics changed its name to National Association of Free and Charitable Clinics. The Virginia Association of Free Clinics re-named itself the Virginia Association of Free and Charitable Clinics. Clinics in Florida recently formed the Florida Association of Free and Charitable Clinics. Several years ago the Georgia Free Clinic Network as it was then called, in a bold move that captured the attention of many, changed its name to Georgia Charitable Care Network. Despite these shifts, many clinics across the country that have "free" in their name continue to embrace their name, claiming to experience no disadvantages in using the term "free," and continuing to enjoy widespread popularity and community support for their brand. Ironically, the "free clinic" brand is so positive in some communities that some clinics have held on to the "free" in their name even after they decided to start charging fees!

At present we lack precise numbers as to how many clinics in the country are totally free, and how many charge patient fees of some kind. The country's foremost researcher on the free clinic sector, Dr. Julie Darnell from the University of Illinois at Chicago, is presently planning to conduct a second nationwide survey of clinics in 2015 (the first one was conducted in 2005–2006), part of which will answer the question of how many free and fee-based "charitable" clinics there are and also to examine more closely the nature of the fee policies themselves.

CASE STUDY NO.1

HANDS OF HOPE CLINIC in Stockbridge, Georgia, was established in 2007 as a free clinic. The clinic recently made a decision to transition to implementing a fee structure for several reasons: to generate revenue due to a budget shortfall; to encourage patients to be more compliant through having "skin in the game"; and, to aid in changing the community and funders' perceptions that patients are not receiving a hand-out and are making their health a priority.

The fee structure was determined by a Fee Work Group appointed by the Board and comprised of Board members, a volunteer dentist, and clinic staff members. After research, the Work Group proposed a fee structure to the Board of Directors, which recently approved it. The fees are as follows:

- Medical Visit - $10 initial visit; $5 follow-up visits
- Dental Visit - $15 initial visit (including all follow-up exams); $20 for extractions, regardless of the number of teeth removed

The fee will be waived for patients who cannot afford it, and this will be determined during the eligibility process and at the discretion of key staff members, as needed. The clinic believes the fee is low enough that they do not anticipate having many patients unable to pay. They have posted signage throughout the clinic informing patients that a fee for services will begin in June 2014. Thus far, the patients have reacted more positively than clinic leaders expected.

The clinic presently has an entity liability insurance policy in place, and is in the process of issuing a bid to purchase malpractice insurance for their providers. They expect the insurance costs will be offset by the patients' fees.

III. Reasons Clinics Consider Charging Fees

There are a variety of reasons that are driving some clinics across the country and in Georgia to decide to charge fees. Arguably the most common reason is a desire to make up for lost funding (due to funders' and donors' perceptions of diminishing need as a result of the Affordable Care Act). Patient fees may not only help make up for budget shortfalls in the near term, but can also lead to a more sustainable and reliable base of support over the long term. This is increasingly attractive to foundations and other institutional funders who are concerned with issues of sustainability and want to see more earned income streams in their grantees' budgets. In fact, a second common reason clinics decide to charge fees is to maintain the support of key existing funders and/or to re-establish ties with previous funders. Sometimes a clinic will make this decision after a key funder has strongly encouraged it to consider charging fees and when not doing so would potentially cause that funder to withdraw its support. In other cases, clinics move to charge fees because they believe it will make their case and their business model more attractive to current and prospective funders.

A third reason that clinics decide to charge fees is the belief that a patient will be more engaged, compliant, and successful in treatment if he/she has some "skin in the game" by virtue of having paid something toward the care. Some clinics point out that individuals from certain cultural backgrounds actually place a higher value on something when they have paid for it. Other clinics are simply convinced that requiring patients to contribute financially to their care is the morally right thing to do and makes for a more "dignified" experience for the patient. Interestingly, a review of the literature does not affirm the view that patient cost sharing leads to more engaged, compliant, and "successful" patients. A number of scholarly studies have been conducted over the years to examine the effect of patient cost sharing on utilization of services, patient adherence to treatment, and health outcomes. The vast majority of these studies conclude that patient co-pays and other cost sharing, particularly among low-income populations, has an *adverse* impact on utilization and compliance and therefore outcomes. Some of the studies demonstrate that even a relatively modest out-of-pocket fee can negatively affect access, utilization, adherence, and overall results of treatment.

Therefore, it behooves clinics to consider these divergent realities when deciding whether to implement a fee structure. While adding patient fees to the income side of the ledger may improve cashflow and overall fiscal health, clinics should weigh carefully what might be sacrificed on the clinical side in terms of potentially diminished utilization, reduced adherence, and poorer outcomes among their fee-paying patients.

CASE STUDY NO. 2

HOPE HEALTH CLINIC in Griffin, Georgia, implemented a fee structure in September, 2011, after merging with a local clinic associated with the county public health department. In 2013, clinic fees paid by patients represented 9% of the clinic's revenue. This revenue is important to the clinic because many outside funders will only cover direct program expenses and a small portion of general operating expenses. The clinic's leadership believes patients take more ownership in their healthcare when they make a personal investment. They know patients value their care and believe paying a clinic or exam fee is their way of helping the clinic remain open. The clinic also leverages this point with donors.

An interesting side note to charging clinic fees: in their case, as a standalone clinic—one not located near a hospital—patients think that because the charge is so small, the clinic providers are not actual medical or dental professionals. Ann Cherette, Clinic Director, believes this speaks loudly to the price/value of the relationship.

The medical visit fee is $20. To ensure the fees are not over- or under-priced, the clinic based them on a survey conducted of co-pays for patients with Medicaid and Exchange-purchased polices. They acknowledge many patients who have signed up for insurance coverage through the Health Insurance Exchange still try to come to the clinic, because the fee is less than their insurance policy's co-pay.

The dental fee structure is 30-35% of the Medicaid fee scale. The clinic researched this as well as the cash fee structure of area dentists to ensure its charges were appropriate. The fees are:

- $20 for an exam, if the patient has booked an appointment;
- $30 for a walk-in exam;
- $25 for extractions;
- $30 for cleanings; and,
- $20 to $40 for restorations, based on the filling material.

If a patient cannot pay the required fees, the clinic asks what the patient is able to pay. If a patient cannot pay at all, he/she is not turned away. At present, the clinic is gathering patient household income figures to establish an appropriate sliding-fee

scale structure. Initially, patients have been reluctant to provide the information, but upon explanation they have cooperated. This request is now reinforced by the PAP programs, which have become stricter as of January 1, 2014, regarding proof of household income.

Hope Health Clinic purchased a professional liability policy to cover the clinic and its mid-level providers. The medical director and the dentist, both employed, provide their own malpractice coverage. The clinic has not made the investment to cover medical volunteers that are licensed but retired. To increase patient capacity, they have utilized medical and dental students. The clinic's liability coverage includes the students, as well as the students' school.

IV. Fee Structures

Most clinics that charge fees set them at a modest level initially. In addition, they typically establish flat amounts rather than complicate matters with the use of a sliding-fee scale based on income. As the establishment of fees is a strategic issue that cuts to the core of a free clinic's mission and philosophy, the ultimate approval of a fee structure usually rests with the clinic's board of directors. While some may doubt the ability of a clinic's very low income patients to pay even modest fees, clinics that start charging fees typically find that a high percentage of their patients can and will pay the fee and that the fees collectively represent a meaningful addition to a clinic's revenues. Some clinics decide, as part of their fee policy, that they will waive fees for those who cannot afford to pay the fee, while others make the fee structure an iron-clad requirement, in some cases setting up alternative sources for patients to tap when they personally cannot afford the fee.

Since dental care is considerably more expensive to provide on a per-visit basis, given the need for costly equipment and consumable supplies, dental clinics and programs are more likely to adopt fee structures initially than their medical counterparts. Some dental clinics have found that the payment of an "appointment fee" upfront reduces patient no-shows and cancellations. Some of these clinics, to further incentivize patients to keep their appointment, will reimburse the appointment fee in part or in full when the patient shows up for the appointment.

Some clinics decide that they should focus their fee structure initially not on a per-visit or services-provided basis but rather on certain *goods or products* that patients need in the course of their treatment. Examples of products that clinics collect a fee for are eyeglasses, medicines, glucometer strips, and dentures.

CASE STUDY NO.3

FAYETTE CARE CLINIC in Fayetteville, Georgia, has operated as a free clinic since opening in May, 2006. It is implementing a fee structure, effective June, 2014, in order to provide health care to the uninsured and underinsured, and because Georgia at present is not expanding Medicaid. Clinic leadership believes it will also strengthen their partnership with the local hospital.

The fee structure is based on household income, and will range from $5 to $75, depending on the service provided. The fee will be waived or adjusted due to individual patient circumstances.

Fayette CARE Clinic will purchase a liability policy to cover the clinic. The providers have agreed to pay their own coverage costs, under a program available for volunteer providers through a regional insurance company.

V. Implementation Issues

The establishment of patient fees, especially by clinics that were previously altogether free, typically occurs following considerable review and discussion by management and the Board, culminating in the adoption of a written fee policy. Management then is typically delegated the responsibility of developing and implementing administrative procedures and processes to comply with the Board policy. Particular attention should be given to the manner in which patients are informed of the fee, at what point and to whom patients must pay the fee, what methods of payment are permitted, and what if any provisions exist to waive the fee and/or refer the patient to secure funds with which to pay the fee. It is advisable to require payment of fees prior to the delivery of services rather than following the services. Some clinics require payment of the fee at the time an appointment is made, so that there are no glitches, delays, or issues with fee payment when the patient comes in for the visit. In addition, policies and processes for receiving, processing, tracking, recording, and depositing the fee payments should exist, which ensure proper internal controls and segregation of duties consistent with generally-accepted accounting procedures. All staff and relevant volunteers should be informed and trained as necessary on the new fee policy and accompanying procedures and processes. More importantly, clinics that are converting from free to fee-based do well to inform the patient population of the fee structure—along with instructions for how and when fees are to be paid—well in advance (typically 3 months or more) of the fee policy going into effect.

It is prudent to plan for a review of a newly established fee policy and procedures at pre-defined intervals following implementation (e.g., 6 months and 12 months). Such a review could include observations of the fee process "in action," interviews of personnel involved in collecting the fee, interviews of patients, compilation and tallying of data on fees collected (as well as the "waiver rate", if applicable), and an assessment of the actual fee policy and procedures themselves. It is not uncommon for minor adjustments to be made following such reviews in the early implementation period. That said, changes in the actual fee structure should only be made after a meaningful period of time has elapsed to assess the current fee structure, and careful attention and thought has been given to the modifications.

VI. Sovereign Immunity Considerations

An important factor for Georgia's charitable clinics to consider in determining whether to remain a free clinic or convert from a free clinic to a fee-based clinic deals with the impact on the clinic's eligibility for state Sovereign Immunity protection through the Georgia Volunteer Health Care Program (GVHCP). The GVHCP, launched in 2006, was designed to increase and promote access to free quality health care for the uninsured

and underinsured. The program achieves this by promoting volunteerism by offering Sovereign Immunity protection to entities and licensed healthcare professionals who donate health care to eligible patients. Eligible patients must have family income at or below 200 percent of the Federal Poverty guidelines, and must not have insurance for the care they are seeking. To protect the volunteer provider, the State of Georgia becomes solely liable for any injury or damages suffered by a patient receiving the free health care, as long as the provider works within the scope of their professional license. It should be noted that to date there have been no lawsuits filed against free clinics or their healthcare providers under the Sovereign Immunity statutes.

Sidney Barrett, General Counsel for the Georgia Department of Public Health which administers the GVHCP, was interviewed for this paper. While he (as well as the author of this paper) cannot provide legal advice, he did offer the following observations and opinions on Georgia's Sovereign Immunity program for free clinics and their volunteers. Voluntary donations are a classic legal "grey area." The law authorizes the benefit of Sovereign Immunity for health care providers under contract with the Department to provide "uncompensated services" pursuant to Code Section 31-8-192(1). While neither the Department nor a court has defined "uncompensated services," a free clinic that requests or accepts even a voluntary financial donation from a patient might make free services look "compensated." It is possible that a clever plaintiff's lawyer might convince a judge that, under the right set of facts, the "donation" was not voluntary, but rather was a quid pro quo for getting the service. Such a case would turn on the particular facts, but the more it looks like the donation was expected, the more likely that the care would not be considered "uncompensated."

An anonymous donation box in a free clinic lobby would likely not make a judge think payment was a condition of getting the services. There could be a different result if the patient is presented with a document (e.g., copy of a superbill) by the clinic showing how much the services would cost if the patient had to pay for it, and a clinic staffer then asked, "Now wouldn't you like to make a donation today?" In short, voluntary donations are not forbidden, but the issue should be approached with caution. Free clinics that wish to maintain their Sovereign Immunity protection should avoid sending a message that patient donations are expected.

For clinics who wish to consider fees for goods rather than *services*, the statutes say that the services must be uncompensated but do not say that a clinic must provide physical goods (e.g., medicines) for free. However, if a clinic charges for such items, then it would not be a good idea to apply a mark-up to those items. Again, while it is difficult to predict how the courts would react, putting a profit margin on goods is a fact that a plaintiff's lawyer would likely use against you.

There is no prohibition against having a totally free program (e.g., medical) alongside a program (e.g. dental) that charges fees. If there is a lawsuit against the free service

provided to the plaintiff, then the clinic and its practitioner(s) who provided the free service will be fully protected, regardless of what other services are offered that may have included fees. However, if there is a lawsuit from a patient receiving a service that charges fees, the sovereign immunity protection for the clinic entity as well as the provider (even if he/she is a volunteer) would not apply. Some clinics would like to maintain protections and require an appointment fee of their patients and reimburse the fee when the patient shows up for his/her appointment. While challenges exist pertaining to "no shows" for free care, charging this type of fee is probably not a good idea for a clinic that wishes to maintain its Sovereign Immunity protection.

The Department of Public Health is considering proposing a statutory amendment in 2015 to allow free clinics to charge a small administrative fee and still maintain their Sovereign Immunity. This is based on reports by volunteer programs in other states that it "actually reduces no shows" and "encourages the patients to assume more responsibility for their care."

VII. Liability Insurance

A free clinic that remains totally free and does not expect or coerce patients to make a donation for services received is free to purchase separate professional liability insurance for its entity and healthcare professionals providing free services, but it would likely be redundant. A free clinic and/or any healthcare professional providing free services who is sued under the Georgia Volunteer Health Care Program would be defended by the Attorney General's office (or its designee) and indemnified by the State's general liability insurance policy for any judgment. A clinic that expects patients to make a donation for services received or that charges fees for services would not be covered for those services by GVHCP and would therefore need to secure professional liability insurance in order to have protection in the event of a medical malpractice claim. There are a number of insurance carriers who write professional liability (medical malpractice) policies in Georgia. While the costs of liability insurance premiums are not insignificant and will certainly add to a clinic's operating budget, they are not insurmountable and can often be offset by the new revenue stream created by patient fees, and then some. Consult with a trusted insurance broker in your community to secure quotes, or contact the Georgia Charitable Care Network for a list of the insurance carriers.

VIII. Summary

There are many factors for a clinic to consider in determining whether and how to charge patient fees. It is not a given that every free clinic will or should eventually convert to a fee-based model. While the addition of patient fees may give a welcome boost to the clinic's otherwise shrinking revenues during challenging times, a raft of evidence exists to show that patient co-pays can have a negative effect on patient access to services, adherence to treatment, and overall outcomes. As with every strategic issue that cuts to the heart of a clinic's mission and purpose within the local healthcare safety net, the decision to charge fees (or not) should be made carefully and purposefully, with input from stakeholders as well as calm deliberation among the clinic's decision-makers. This issue, like so many in our sector, is likely to remain a very local choice, driven by unique community needs, preferences, and mores.

About the Author

Mark Cruise has more than 20 years of leadership, management, and consulting experience within the free and charitable clinic sector. Following a stint as executive director of a free medical and dental clinic in southwestern Virginia, he directed the Virginia Association of Free Clinics from 1997–2006. Since 2006, he has led a national consulting organization called Free Clinic Solutions, which has served more than 80 free/charitable clinics, associations of clinics, health foundations, and suppliers. In 2008 he wrote *Engaging Volunteers for Better Healthcare in Georgia* for the Healthcare Georgia Foundation. In 2010 he was commissioned by the Georgia Charitable Care Network to write a 65-page publication entitled *A Guide to National Health Care Reform for America's Free and Charitable Clinics*. Mark wishes to acknowledge the executive director of the Georgia Charitable Care Network, Donna Looper, for her valuable assistance in researching and reviewing this paper.

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About Heathcare Georgia Foundation

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