

UNITED STATES OF AMERICA  
BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH RESOURCES AND SERVICES ADMINISTRATION

COMMENTS OF WHITMAN-WALKER HEALTH ON  
REQUEST FOR INFORMATION: ADMINISTRATIVE STREAMLINING  
AND BURDEN REDUCTION

Whitman-Walker Health (WWH or Whitman-Walker) is pleased to submit these comments in response to HRSA's May 1, 2018, Request for Information: Administrative Streamlining and Burden Reduction, <https://www.hrsa.gov/about/news/press-releases/rfi-administrative-streamlining-burden-reduction>. We support HRSA's efforts to identify and reduce inefficient and unnecessary administrative burdens in order to increase the effectiveness of the Ryan White Program and other HRSA-administered public health programs and ensure maximum benefits for the low-income people living with HIV or other serious medical conditions, or in need of primary care.

**Interest of Whitman-Walker Health**

Whitman-Walker is a Federally Qualified Health Center serving greater Washington, DC's diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in HIV care and serving lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) populations. We empower all persons to live healthy, love openly, and achieve equality and inclusion. Our health center provides high quality, affirming health care to more than 20,000 individuals annually and is the medical home to more than 10,000 patients. The center has five sites and a team of more than 280 highly educated and practically experienced staff.

WWH services include primary medical care, HIV and LGBTQ specialty care, oral health, mental health care, addictions treatment services, psychosocial support, medical

nutrition therapy, early intervention services, public benefits and insurance navigation, nurse-focused case management, HIV and STI screening, legal services, youth programs, and an onsite pharmacy. The health center has achieved Level 3 Patient Centered Medical Home accreditation with the National Committee for Quality Assurance.

A programmatic innovation, which was a major success and led to changes in the regional provision of immediate HIV care, is our Red Carpet initiative. This program ensures that individuals newly diagnosed with HIV, or HIV-positive and new to care at Whitman-Walker, receive immediate services at any WWH site. Clients receive an evaluation of emotional, social, psychological and physical needs and public benefits and health insurance needs to ensure all programs and assistance to reduce cost of care are accessed.

WWH began in November 1973 in a church basement as the Gay Men's VD Clinic. Officially chartered in 1978, Whitman-Walker Clinic, Inc. took the lead as the HIV/AIDS epidemic developed. As the organization grew, goals broadened beyond HIV until WWH matured into the full-service health care center that exists today. To better reflect our broad mission, the organization began doing business as Whitman-Walker Health in 2011.

WWH has received Ryan White funding since the inception of the grant program in 1990. WWH's service area is the greater Washington, DC metropolitan area; we serve more than 20% of the District of Columbia's reported HIV-positive population, many of them low-income or members of otherwise underserved communities. Our patient populations include: African Americans; Hispanic individuals; men who have sex with men (MSM); substance users; low income and homeless individuals; and transgender persons. Of DC's reported Ryan White patients, WWH serves 30% and diagnosed 30% of the new HIV cases in 2016 via a robust HIV testing program.

## Comments Pertaining to HRSA's Bureau of Primary Health Care

*RFI Section A.1.* Currently, health centers are required to submit their UDS data to a reporting system annually, between January 1 and February 15. Historically, BPHC's receiving system for UDS data does not open for data entry until January 1. One change to this reporting process being explored is to offer health centers the option to access the UDS data-reporting environment earlier than January 1. This new option, referred to as the Performance Data Collection Environment (PDCE), will give health centers more time (from September 1 to December 31—one quarter prior to the start of the official reporting period) to populate their UDS reports and perform validation on data entered to ensure accuracy and integrity. This extension gives health centers the option to export their UDS data entered in PDCE into the “live” data reporting system when it opens on January 1. In addition, the new option will allow health centers new to UDS reporting to familiarize themselves with the UDS reporting system and the most current data reporting requirements. BPHC is hopeful that PDCE will decrease the burden on both health center and BPHC staff time and resources during the official reporting season, when UDS data are vetted, which often involves back and forth between health centers and UDS data reviewers for questionable data entries.

*WWH Response to RFI Section A.1.* Having the opportunity for new starts (newly-funded FQHCs) to view the UDS and understanding how it looks in the EHB could be useful. This year BPHC released the UDS guidelines earlier than in previous years, which is also useful. However, practically speaking, having the data portal open earlier – and before the reporting term ends – is not useful and could lead to double entry/incorrect data issues at submission.

BPHC should consider extending the reporting deadline from the middle of February until the end of February, to allow health centers ample time to close the reporting period and verify data integrity. Opening up the reporting period to give access earlier will not achieve the desired result.

*RFI Section A.2.* Additionally, BPHC is considering the feasibility and impacts of providing health centers an option for transporting UDS data more directly from their electronic health records (EHRs) and other systems to BPHC for the purposes of annual administrative data reporting. HRSA is seeking comments on: the technical opportunities and challenges for implementing such an option; the potential impact on time spent to extract, transform, integrate, and submit data; and whether such a change would have beneficial impacts on report standardization.

*WWH Response to REFI Section A.2.* For most centers, the UDS necessitates the use of multiple internal data systems. Health centers use a variety of electronic health records, electronic dental records, practice management systems, financial reporting systems, human resources information systems and platforms which extend data reporting optionality. WWH cannot ascertain the impact of directly submitting data to BPHC as compared with what is currently required of us, without knowing which data points would be targeted for direct export and the manner in which those data would be submitted. eClinicalWorks, the EHR that WWH uses, has a built-in UDS reporting function. In order to use that report, WWH would need to map all data elements to the UDS templates, which would also require major changes in work-flows. WWH has not taken this step because our testing indicates that the report generated is not as accurate as the one we produce from our data warehouse. While it is possible that most of the UDS clinical and patient population data could come from an EMR-exported report, much of the required data is housed in separate financial and personnel systems. The current system of entering aggregate data into the EHB is superior given the multitude of data sources needed to complete the report. WWH recommends that the BPHC connect with the EMR vendors who serve FQHCs early in this exploratory phase in order to gain a detailed understanding of the capacity of these EMRs to produce accurate and complete dashboards and reports. Given the diversity of health center systems and the technical talent pool needed to retrieve and analyze these data sets, BPHC would likely need at least three years to implement a change and test the data validity after the change.

*RFI Section A.3.* BPHC is considering changes to the content of the UDS to reduce reporting burden while increasing analytic value for health centers and the Agency. Changes BPHC is exploring include utilizing data algorithms to more efficiently extract patient data based on countable clinical visits from an anonymous database to populate multiple tables in the UDS, including clinical socio-demographic information. This process would replace the current process of independently pulling data each time a health center populates a single UDS table.

Additionally, BPHC is considering the value, given the time and effort involved, of reporting UDS Table 6A elements (selected diagnoses and services rendered). Perhaps some of the clinical information in Table 6A can be retired, since it duplicates content in Table 6B: for example, reporting Pap tests administered in Table 6A and the cervical cancer screening clinical quality measure reported in Table 6B.

*WWH Response to RFI Section A.3.* WWH welcomes the automation of data tasks as long as the algorithms can be shown to statistically comparable to our current measurements and centers are able to participate in the design and testing phase. Whether changes would be beneficial will depend on what data algorithms are used, what kinds of human resources would need to be in place in order to validate and monitor the extraction on the health center side, and the extent to which these algorithms would necessitate a change to current clinical documentation practices.

WWH does not find the production to Table 6A to be particularly burdensome, from a technical point of view. Many of the variables in Table 6A measure quantities – for example, numbers of people who have HIV. They do not, however, measure quality – for instance, how many people with HIV have achieved viral suppression. Quantities are of some interest to us on the health center side but are not as actionable or impactful as the quality outcome information tabulated in Table 6B. Although there is some overlap between the two Tables, any efforts to streamline what is reported in Table 6A and Table 6B should focus on the quality of the care delivered, and should be guided by a team of medical, behavioral, and dental health care clinicians.

### **Comments Pertaining to HRSA’s Healthcare Systems Bureau**

*Section B.1.* HSB also administers and provides oversight for the Hill-Burton Program. Created in 1947 under the Hospital Survey and Construction Act, the Hill-Burton Program provided grant funds to health care facilities to build, renovate, or buy equipment. In exchange, these health care facilities signed either a 20-year obligation or an obligation in perpetuity (or until the facility closes or is sold) to provide low or no-cost health care to income-eligible patients. Although the Hill-Burton Program stopped awarding funds in the 1990s, there are

minimum requirements that recipient facilities must meet annually and report to HSB every-other year. HSB is considering changes in information collection that might reduce burden while maintaining compliance to the Hill-Burton requirements. These changes may involve decreasing the frequency of reports to HSB from every-other year to once every three years. HSB seeks public comments concerning the impact of this change and invites suggestions on other potential changes to Hill-Burton reporting requirements.

*WWH Response to RFI Section B.1.* HSB may want to consider other regular reporting that is provided to HRSA, such as the UDS to BPHC, or Single-Audits to the clearinghouse, to determine if those reporting mechanisms might satisfy Hill-Burton requirements.

### **Comments Pertaining to HRSA's HIV/AIDS Bureau**

*RFI Section C.2.* Grant recipients and sub-grant recipients submit annual Ryan White Services Report (RSR) client-level data for eligible clients who receive a RWHAP-funded service. However, grant recipients and sub-grant recipients do not submit reports for clients who receive services that are fully funded using RWHAP-related funding, such as rebate dollars or RWHAP-related program income. As more grant recipients fully fund services using other RWHAP-related funding streams, less information is available on RWHAP eligible clients and service utilization. This limits HAB's and grant recipients' ability to measure the investment and impact of all RWHAP-related expenditures at State and local levels. HRSA proposes to change client-level reporting to include eligible clients who receive RWHAP allowable services that were funded using RWHAP and RWHAP-related funding (e.g., direct RWHAP funding, sub-grant recipient funding, program income, and RWHAP ADAP rebates) starting with the 2019 RSR. HAB is seeking public comment to better understand the benefits and challenges that grant recipient and sub-grant recipients would experience with this reporting change.

*WWH Response to RFI Section C.2.* General Comments: HAB should take this opportunity to more clearly define the discrepancies between Ryan White-funded services and Ryan White eligible clients. Whitman-Walker serves many more HIV-positive patients who are eligible for Ryan White services, than are paid for by the amount of funding we receive. We suggest that HAB ask grantees to provide data on their total patients diagnosed with HIV; total patients diagnosed with HIV who would qualify for Ryan White services given income and other requirements; and the number of such individuals actually covered by funds provided.

That HAB is receiving less data via the RSR, is as a direct result of unclear and sometimes contradictory guidance from HAB regarding which persons are eligible for services.

HAB should not change client-level reporting requirements to be inclusive of all Ryan White eligible clients funded directly by Ryan White monies, by sub-grantee funds, by program income and by ADAP rebates, without first clearly issuing guidance that clarifies the related issue of eligibility.

With higher levels of health insurance available for our patients, many living with HIV do not always directly benefit from Ryan White services, as their insurance pays for those services. While Ryan White provides some support for insurance navigation and medical adherence nurse staff, there may not be a direct patient service level benefit being provided. This means that patients do not understand why they must provide the personal information required for Ryan White reporting when they do not see what service it is paying for.

Health care providers like WWH, located in jurisdictions such as the District of Columbia which have expanded health insurance eligibility (through Medicaid expansion and higher income/asset thresholds), are penalized in that they cannot claim Ryan White clients for medical or behavioral health services – even though those clients receive many services that are uncompensated which we are still providing. Ryan White guidance is unclear around allowing the “treatment completion concept” where insurance covers some aspect of an eligible patient’s care and Ryan White wraps around what was covered by insurance to cover the rest of the care. Without the ability to apply the "treatment completion concept," these services that are not fully paid for or that health centers provide as wrap around go unfunded. HAB should take every opportunity, not prevented by clear legislative language, to enable and encourage Ryan White programs to provide wrap around services and fund care completion. National data indicates that persons who access Ryan White services enjoy better health overall than those who do not. These wrap around services and care completion promote better health outcomes.

*RFI Section C.3.* HAB has provided consistent policy guidance on the annual eligibility screening and six-month recertification of eligibility for RWHAP clients (HIV/AIDS Bureau's PCN 13-02, "Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements (PDF - 40kb)"); however, RWHAP grant recipients remain challenged to implement the policy in the field. Formal reviews and grant recipient reporting describe several inconsistencies in the application of the recertification requirement by RWHAP grant recipient. In addition, some grant recipients report that the recertification requirement is burdensome as many of their clients do not experience income or healthcare coverage changes significant enough to disqualify them for RWHAP services. HAB is seeking input to understand the impact and burden of the six-month recertification policy to assess RWHAP client eligibility for services. HAB is considering how to minimize the impact on patients' access to medical services, retention in care, access to HIV antiretroviral medications, and ultimately reaching viral suppression.

*WVH Response to RFI Section C.3.* The six-month recertification requirements are too burdensome on patients and providers. The work necessary for a six-month recertification includes: contacting each patient to notify about the need for new documentation, which generally includes sending a letter to the patient and then following up by phone or otherwise; meeting with each patient to obtain the new documentation; scanning that documentation in the patient's electronic health record and making other necessary additions to the medical record. This process is labor intensive for both the patient and the staff. The process burdens, and in effect, stigmatizes Ryan White clients by putting them through a burdensome process that their peers, not designated as Ryan White clients, do not experience. Many requirements do not change from the previous six months, so clients are required to submit much of the same information for each recertification. Many if not most public insurance and public benefit programs require annual recertifications. In addition, with the advent of "passive recertifications" for many programs, the state agency matches information electronically to confirm continuing eligibility and a beneficiary frequently needs to provide no additional documentation or to take any further action to, e.g., continue their Medicaid. Moreover, many patients must recertify even though their medical or behavioral health care is covered by their



Medicaid or other insurance, not by Ryan White – because Ryan White pays for a portion of some of the indirect services they receive such as appointments with insurance navigators or medical adherence nursing staff. This means that these patients are experiencing significant recertification burdens when they do not see the benefits they are receiving in return.

For all these reasons, we urge HAB to transition to annual rather than six-month recertification. This would substantially reduce burdens on clients, and free up staff time and resources to help eligible clients to fully access other benefits that may be available to them in their states.

### **Comments Pertaining to HRSA’s Office of Federal Assistance Management**

*RFI Section E.2. Post-award Process.* OFAM is interested in feedback on actions or requirements that are burdensome in the post-award process for organizations managing single or multiple HRSA grants. OFAM is especially interested in any input on the use of expanded authorities. These are operational authorities provided to recipients that automatically waive the requirement for prior approval for specific actions, e.g., carryforward unobligated balances to subsequent periods of performance, no-cost extension, etc. HRSA is looking to determine if an increased use of those authorities would be beneficial in reducing recipient burden.

*WWH Comments on RFI Section E.2.* It would significantly reduce grant recipient burdens if the process of carrying forward unobligated balances to subsequent performance periods were streamlined. While the increase of the use of expanded authorities may be helpful to reduce recipient burden, WWH’s current experience is that the burden is augmented because of agency delay rather than by the requirement to receive prior approval for specific actions *per se*. Currently, carryover requests often take more than a month to process, which can create inconsistencies in budget amounts that are themselves time-consuming to identify and adjust.

Additionally, instructions for carryover requests should be simplified and clarified. The current instructions are less than clear and subject to multiple interpretations. Lastly, when the recipient receives an updated NOGA in the post-award process, there can be significant

challenges. Grant recipients often receive multiple NOGAs for the same grant period for a variety of reasons. While each NOGA contains dates and a grant numbers, it can be difficult to track which NOGA is current for which funding stream. This makes it more challenging to ensure that all requirements for each grant are fully met.

*RFI Section E.3. Notices of Funding Opportunity.* OFAM is interested in receiving feedback from both current recipients, and past, present, or future applicants regarding the clarity of its Notices of Funding Opportunities (NOFOs) published on Grants.gov. Specifically, OFAM would appreciate suggestions as to how HRSA may streamline and improve the clarity of its NOFOs, so that applicants have a better understanding of what is required of them to submit a high quality application. HRSA would also like feedback on how OFAM may 5/8/2018 improve communication and technical assistance associated with submitting an application in response to a NOFO posted on Grants.gov

*WWH Response to RFI Section E.3.* The NOFAs that HRSA is currently publishing on Grants.gov generally are clear in their requirements. There is, however, often confusion around what portion of the grant application is required to be submitted into Grants.gov and what portions into EHB. If it were possible to streamline the two so that all components of all application could be submitted through a single portal, that would significantly reduce burden.

When WWH does receive comments on applications submitted, the comments are helpful. However, WWH does not consistently receive comments on all grant applications submitted to HRSA, and it would greatly improve WWH's understanding of what is needed to submit a high-quality application if we did receive comments consistently.

## Conclusion

Thank you for this opportunity. If we can provide additional information or be of assistance in any other way, please contact Meghan Davies at [mdavies@whitman-walker.org](mailto:mdavies@whitman-walker.org) or (202) 797-4454.

Respectfully submitted,

A handwritten signature in cursive script that reads "Daniel Bruner".

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