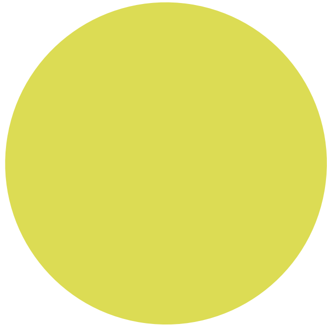

Hospital Community Benefits and Free Care Programs

An Initial Study of Seven Long Island Hospitals

Long Island Health Access Monitoring Project
The Long Island Coalition for a National Health Plan
P.O.Box 382 Hicksville, N.Y. 11802-9998

March 2001

Preface

The Long Island Coalition for a National Health Plan was established in 1988 in response to the growing concern about health care access. It is a grassroots, all volunteer coalition of a broad group of 50 regional organizations and several hundred individuals.

The Coalition's primary goal is to achieve a universal, comprehensive, accessible, and affordable health care system as the most logical and cost-effective solution for the nation's and Long Island's health care needs. The Coalition engages in education and advocacy in order to reach this goal.

Because of its concern with access to healthcare, the Long Island Coalition has always involved itself in local health access issues and has taken a leading role in attempts to preserve public health facilities and prevent privatization.

Early in 2000, the Long Island Coalition for a National Health Plan decided to try to improve hospital community benefit programs at local health care institutions. The goal of this effort was the expansion of access to healthcare for the uninsured and underinsured population on Long Island. For the express purpose of this project the Coalition established a separate arm—the Long Island Health Access Monitoring Project.

With a contract from The Access Project and with technical assistance from Community Catalyst, several surveys were developed. Monitoring Project members conducted a free care survey and performed an analysis of community benefits reports. The recommendations developed are the basis for this report. An additional report, focusing on the results of a survey of healthcare needs, will be issued later this spring.

The Access Project is a national healthcare initiative supported by The Robert Wood Johnson Foundation and the Annie E. Casey Foundation. It works in partnership with the Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University and the Collaborative for Community Health Development and began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that improve healthcare access and promote universal coverage, with a focus on people who are without insurance.

Community Catalyst is a national organization that works with consumer advocacy groups to expand access to quality healthcare for all, including the most vulnerable. Its mission is to build consumer and community participation in the shaping of the U.S. health system. Community Catalyst helps state and local consumer health groups develop the legal, policy, and organizational tools needed to cope with the changes transforming healthcare.

Acknowledgements

We would like to thank our advisory board and the many volunteers whose enthusiasm and persistence made this project happen. We are also grateful for the cooperation extended to us by numerous community-based agencies, groups, and religious organizations. They generously shared staff, gave us access to client populations, and helped recruit surveyors. We owe particular thanks to the Economic Opportunity Commission of Nassau County, Inc. for their support and the generous use of their space and to Mary Dewar, RN for stepping in whenever an extra pair of hands was needed.

We also want to acknowledge the generous assistance of The Access Project and Community Catalyst without whom we could not have completed this project. Special thanks for the generous help given us by our consultant, Debbie Katz, and to Renee Marcus Hodin, who did the legal research upon which this project is based. Both work for Community Catalyst and have been very helpful during this entire process.

Linda Wenze, Ph.D., Associate Professor for the Department of Health Care and Public Administration at Long Island University, C.W. Post Campus, did the analysis of the free care surveys and the hospital community benefits plans upon which this report is based.

If you have any additional questions or would like to learn more about the work of these groups, please contact them directly:

LONG ISLAND COALTION FOR A NATIONAL HEALTH PLAN

P.O.Box 382
Hicksville, N.Y.11802-9998
Project Directors:

Rosemarie Guercia, M.D.
(631) 549-2714
ladydoctor@aol.com

Donna Kass, P.T.
(516) 829-1225
doka@erols.com

THE ACCESS PROJECT

30 Winter Street, Suite 930
Boston, MA 02108
(617) 654-9911
www.accessproject.org

COMMUNITY CATALYST

30 Winter Street, 10th Floor
Boston, MA 02108
(617) 338-6035
www.communitycat.org

Executive Summary

The Long Island Health Access Monitoring Project (LIHAMP) is sponsored by the Long Island Coalition for a National Health Plan. In the summer of 2000, it set out to determine how seven nonprofit hospitals in western Suffolk and Nassau Counties were fulfilling their obligations to provide needed services to the communities they serve. The overall objective was to determine what local hospitals say and do about community benefits and free care for the uninsured. Based on the findings of this initial pilot study, the Coalition has developed recommendations that hospitals, state government, and community members will be encouraged to use in order to improve the quality and responsiveness of hospital free care and community benefits programs.

BACKGROUND

Traditionally, most hospitals have been nonprofit institutions formed for charitable purposes. This means they are generally exempt from local, state and federal taxes, and are able to solicit tax-deductible donations. This financial benefit is intended to allow nonprofit hospitals to provide needed services—usually called *community benefits*—to the community. In addition, because of health care's "public utility" nature, all hospitals, regardless of tax status, can be seen to have a minimum corporate social obligation to provide some amount of these essential services to those who are otherwise unable to pay.

In recognition of the importance of community benefits, New York State's Health Care Reform Act, enacted in 1996 and modified in 2000, includes provisions intended to ensure that nonprofit New York hospitals are providing community benefits **and** are directly involving the community in identifying what programs are most needed.

Among community benefits, the most important is *free care*—or charity care, as it is sometimes called. Free care is medical care provided to low income, uninsured people by a hospital or other provider for which it does not expect to be paid. Patients do not face the obligation of any debt associated with these services. For low-income people who are uninsured or have only limited coverage, free care may represent the only avenue to necessary medical treatment. Recent IRS advisement has underlined the importance of providing free or low cost care and of making charitable care policies known to the public as a requirement for maintaining tax-exempt status.

New York hospitals have an important advantage shared by hospitals in only a handful of other states. The state operates a free care/bad debt pool aimed at partially reimbursing hospitals for unreimbursed costs, which include both free care and bad debt. Unlike some of the other states, however, New York has not established standards to assure that pool funds are used equitably. For instance, there are no income eligibility guidelines, uniform application procedures, or requirements for public notice of the availability of free care. Nor has the state established a standard for the proportion of gross service revenues to be dedicated by hospitals to free care.

ABOUT OUR STUDY

An initial study was undertaken during the spring and summer of 2000 in order to identify area hospitals' community benefits and free care policies, priorities and practices. We took two approaches to obtaining information about these policies. First, we conducted a free care monitoring survey at each of the seven hospitals. Second, we systematically reviewed the documents each hospital must submit to the state under the Health Care Reform Act that relate to community benefits. This information helped us form a "profile" of the hospitals' efforts in these two related areas.

The seven area hospitals were chosen for this initial effort because they represent diverse health systems and varied locations within the area. The hospitals studied include:

Nassau County Hospitals

Long Beach Medical Center

Mercy Medical Center

Nassau University Medical Center

North Shore University Hospital

Winthrop University Hospital

Suffolk County Hospitals

Good Samaritan Hospital Medical Center

Huntington Hospital

THE FREE CARE SURVEY

A free care monitoring survey was conducted in which several surveyors called or visited each of these hospitals using a standard protocol to inquire whether the hospital provided free care and if so, what its policy was for making it available.

AMONG THE KEY FINDINGS WERE:

- At none of the seven hospitals did staff consistently inform surveyors that free care was available.
- Some surveyors at four hospitals were told that free care to low income, uninsured individuals was available, while other surveyors were told that free care was unavailable. (At the other three hospitals, staff consistently informed surveyors that **no** free care was available.)
- Only one hospital provided a written free care policy upon request.
- Uninsured surveyors had a much harder time obtaining responses to their questions than surveyors calling from community agencies or faith-based organizations. Non-English speaking surveyors were almost never able to obtain information on free care from any of the hospitals.

THE COMMUNITY BENEFITS REVIEW

In addition to the free care survey, researchers reviewed the seven hospitals' mission statements, community service plans and financial reports related to the cost of charity care, documents required to be submitted to the state in order to comply with the provisions of the Health Care Reform Act that relate to community benefits. These documents are intended to allow state officials and other interested individuals to understand what community benefits hospitals provided and how the community played a role in determining these benefits.

AMONG THE KEY FINDINGS WERE:

- Materials were often difficult to obtain.
- The reports were often incomplete. As presently prepared by the hospitals, the reports are quite different and, often, hard to follow.
- Little or no detail was provided about the priorities identified by the community and the hospitals' implementation of a community benefits program that reflected these priorities.
- There is a lack of clarity about the state's expectations with regard to the requirement to demonstrate financial and operational commitment to charity care services and improving access to health services for the underserved.

RECOMMENDATIONS

Based on the findings, the Long Island Coalition for a National Health Plan recommends that:

Hospitals:

- ❑ Provide free care to individuals with incomes below 150% of the federal poverty level ($12,885 for an individual, in FY 2001).
- ❑ Adopt and prominently display uniform free care policies.
- ❑ Include all applicable fees and services when providing free care.
- ❑ Make available information about free care in a culturally competent manner in those languages that are common in the area.
- ❑ Institute advisory boards composed of representatives from a cross-section of the service area's population in order to obtain community input regarding priority community benefits.
- ❑ Employ additional methods, such as public meetings, surveys and interviews, to obtain community input, and use this input to craft their community benefits programs.
- ❑ Disclose changes made to services and community benefits resulting from recommendations made by community representatives, as well as progress towards achieving the previous year's identified objectives.

Government Agencies:

- Adopt standard income eligibility for free care at no lower than 150% of the federal poverty level.
- Make hospitals' eligibility for public monies dependent on their delivery of charity care by establishing an expected proportion of gross revenues devoted to charity care.
- Develop minimal requirements for hospitals' provision of free care and actively monitor compliance.
- Be more specific about the documentation required of hospitals in order to comply with the community benefits provisions.
- Develop a consistent reporting format and apply a financial penalty if hospitals fail to provide the required information.
- Review the reports and hold hospitals accountable for proposed activities.
- Monitor compliance with community benefits requirements and apply penalties when appropriate.

Community:

- Work closely with local hospitals to craft new free care policies that are responsive to the needs of the community.
- Publicize the availability of free care.
- Monitor and report on hospital performance with regard to free care and community benefits activities.
- Participate in hospital advisory boards.
- Actively seek involvement in identifying and implementing community benefits.

Introduction

The Long Island Health Access Monitoring Project set out in Summer 2000 to determine how nonprofit hospitals in western Suffolk and Nassau Counties were fulfilling their community benefits and free care obligations to the community. The project, sponsored by the Long Island Coalition for a National Health Plan—an all-volunteer, grassroots organization—initially conducted legal research on New York state laws and regulations that apply to local hospitals. (This work was done in cooperation with The Access Project, a national healthcare initiative.) Subsequently, the project requested and reviewed hospitals' reports on their community benefits programs, and investigated free care programs and practices. The overall objective was to determine what local hospitals say and do about community benefits and free care for low income, uninsured individuals. Based on the findings of this initial study, the Coalition has developed recommendations hospitals may use to improve the quality and responsiveness of their programs and responsible authorities may use to clarify and strengthen regulations.

WHAT ARE COMMUNITY BENEFITS?

Community benefits are the unreimbursed goods and services provided by local health care institutions that address community-identified health needs and concerns. In simpler terms, they are the things that a hospital does that improve the health of the community, but for which the institution does not expect or receive payment. Some common examples of community benefits include free or "charity" care at hospitals, health education campaigns, free health screenings, free flu shots, and so on.

Traditionally, most hospitals are nonprofit institutions formed for charitable purposes. This means they are generally exempt from local, state and federal taxes, and are able to solicit tax-deductible donations. These financial benefits are intended to allow nonprofit hospitals to provide needed goods and services to the community. And the amount of money hospitals save because of these tax exemptions can be quite sizeable. One hospital in our study, for example, saves over $20 million annually in property taxes alone[1].

Recently, the IRS issued an "advisory" to its field agents outlining what can be expected of nonprofit hospitals in order to demonstrate they are meeting the community benefit requirements to maintain their tax-exempt status. According to the February, 2001 document, a nonprofit hospital "must show that it actually provided significant health care services to the indigent." In order to document that a hospital is meeting its tax-exempt obligations, agents are instructed to determine, among other things, whether the hospital has a "specific, written plan or policy to provide free or low-cost health care services to the poor or indigent", whether it makes the "terms and conditions of its charity policy" public, and "what inpatient, outpatient, and diagnostic services" are actually provided as free or reduced price care.

---

[1] Nassau County Tax Assessor's Office, Mineola, NY.

The obligation to provide free care and other community benefits is also rooted in the concept that essential core services carry with them a minimum corporate social responsibility. Health care most certainly is an essential core service. The absence of health care services can have catastrophic results for individuals and families and can adversely impact the well-being of communities. Because of health care's "public utility" nature, all hospitals, regardless of tax status, have a minimum corporate social obligation to provide some amount of these essential services to those who are otherwise unable to pay.

Until recently, it was left to health care institutions to decide on their own how much money to devote to community benefits and what benefits to provide. As a result, some institutions provided a great deal in the way of community benefits and others provided very little. Recent changes in the health system, however, have led community groups and public officials to pay more attention to community benefits. The health care system is increasingly market-oriented and competition among hospitals can result in new fiscal constraints. The pressure to focus on their bottom lines may lead hospitals to reduce or eliminate critical, but unprofitable, community services.

In order to preserve community benefits in a more competitive health system, legislators in thirteen states, including New York, have adopted laws to ensure that hospitals provide community benefits and to ensure that the community is involved in identifying community benefit needs[2].

NEW YORK COMMUNITY BENEFITS LAW

In 1996, the New York state legislature enacted the Health Care Reform Act, which directs nonprofit hospitals to demonstrate their commitment to providing charity care and improving access for the underserved.

The statute[3] requires the following:

Every year, hospitals must:

- File their mission statements.
- Submit an implementation report on their performance meeting the health care needs of the communities, providing charity care services, and improving access to health services for the underserved.

Every three years, the hospital's board must:

- Review and modify the mission statement as necessary.
- Seek the views of the communities regarding issues such as the hospital's performance and service priorities.
- Demonstrate the hospital's commitment (including financial) to charity care services and to improved access for the underserved.

---

[2] Compendium of Community Benefit Laws, available at www.communitycat.org.
[3] Codified at N.Y. Pub.Health Law § 2803-1.

- Prepare a statement showing the hospital's resources and what portion were devoted to free or reduced price services or efforts to increase access.

These reports must be submitted to the NY Commissioner of Health and must be made available to the public. The reports provide an opportunity for New York authorities to determine how nonprofit hospitals are fulfilling their charitable obligations and whether they are involving the community as directed by the law.

WHAT IS HOSPITAL FREE CARE?

Free care—or charity care, as it is sometimes called—is medical care provided to low income, uninsured people by a hospital or other provider for which it does not expect to be paid. For low-income people who are uninsured or have only limited coverage, free care may represent the only avenue to necessary medical treatment. It is an essential safety net for many working individuals and families who are not eligible for coverage through government programs like Medicaid or Medicare, and who do not get health insurance through an employer. As such, it is considered a key community benefit.

The unavailability of free care can have a catastrophic impact on individuals and families. In some cases, low-income people may avoid seeking essential—even life-saving—care if they lack funds to pay for services.[4] People without insurance often seek care at a hospital emergency room, which is not set up to provide the follow-up or on-going care that might be required. If an individual receives care for which he or she cannot pay, the hospital may start collection proceedings. Ultimately, the patient's credit rating can be ruined and some may be forced to file for bankruptcy, either of which can affect access to other basic human needs, such as housing and automobiles needed for travel to work.

If a person is eligible and approved for free care by the hospital, the hospital **does not** expect to be paid[5]—and the hospital should not send bills to a collection agency. Thus, free care is different from what hospitals call *bad debt*. Bad debt is money that is owed for hospital services for which the hospital **does** expect to be paid. It is a cost of doing business in any industry. Bad debt is just as likely to result from unpaid insurance claims or the unpaid co-insurance amount for a higher-income, insured individual as it is to result from a lower-income, uninsured person who cannot afford to pay for care. To the extent that free care funds may be limited, it is important that they be properly targeted to those with demonstrated need and not used as a substitute for hospital collection activity when there is an ability to pay.

NEW YORK STATE UNCOMPENSATED CARE POOL

New York hospitals have an advantage shared by hospitals in only a handful of states. The state operates a free care/bad debt pool[6] aimed at partially reimbursing hospitals for unreimbursed costs, which include both free care as well as bad debt.

---

[4] Ayanian, JZ, Weissman,JS, Schneider, EC et al. Unmet Health Needs of Uninsured Adults in the United States, JAMA 2000; 284:2061-2069.

[5] Miller, M, *The Free Care Safety Net*, Boston: The Access Project, 1999. Available at www.accessproject.org.

[6] Codified at NY CLS Pub Health §2807 et seq.

The pool is funded by Medicaid and insurers, as well as hospitals and other health agencies, which pay a percentage of their revenues into it. Hospitals are reimbursed from the pool through a complex formula based in part on the level of unreimbursed care they provided compared to other hospitals and the proportion of unreimbursed care to their total costs. Some funds are reserved for *high need hospitals*, those that provide greater proportions of unreimbursed care.

In order to qualify for distributions from the pool, hospitals must submit monthly and yearly financial information. Hospital costs related to free care and bad debt for the uninsured must be reported separately from hospital costs representing deductibles and coinsurance for insured patients. In addition, hospitals must institute minimum debt collection procedures and participate in a prenatal care program for medically underserved patients (if they deliver obstetrical care).

Unlike pools in some other states[7], New York has not established standards to assure that pool funds are used equitably. Examples of such standards in other states include:

- Income eligibility for free care is specified.
- Posting standard signs informing patients of free care policies.
- Establishing a grievance procedure for persons denied free care.
- Using a standardized application to determine eligibility.

Nor has New York established a minimum amount of free care as a proportion of gross service revenues as have Rhode Island and Texas.[8]

SCOPE OF THIS REPORT

Based on the discussion above, the Long Island Health Access Monitoring Project has been interested in assessing how area hospitals are fulfilling their community benefits and free care obligations. The seven area hospitals (listed in the Executive Summary) were chosen for the initial study since they represent diverse health systems and varied locations within the area.

Community Benefits reports, required by statute, were requested of each hospital and of the New York Department of Health. In addition, volunteers contacted the hospitals to determine what information uninsured individuals or agency representatives could obtain about free care at the institutions. By combining these data, researchers could gain an important perspective on each hospital's community benefits and free care policies, priorities and practices.

---

[7] See, for example, Massachusetts Administrative Code 114.6 CMR 10 et seq, Ohio Administrative Code 5101:3-2-0717, New Jersey Administrative Code 27 NJR 1995.

[8] See Texas Health and Safety Code, Chapter 311, Subchapter D and 52 Rhode Island Govt. Reg. 49,51.

Free Care Survey

METHODOLOGY

The Long Island Health Access Monitoring Project conducted a survey to see how easy or difficult it is to find out about the availability of free care. The survey was administered in every case by three different categories of individuals: 1) uninsured people; 2) social service agency staff; 3) faith-based volunteers. The survey was designed to find out if hospitals had explicit free care policies, whether hospital staff knew about these policies and provided uniform information to the public, whether people requesting information about free care were treated respectfully, and if people who spoke in languages other than English could obtain the requested information. (Long Island communities have large numbers of Spanish and Haitian Creole speaking immigrants.)

The survey methodology was simple. Three groups of surveyors were recruited. Uninsured community residents were paid a small stipend for their efforts. Social service agency staff and faith-based individuals volunteered their time. They were all trained by Community Catalyst staff to make telephone inquiries and site visits to the seven selected hospitals, seeking information about the availability of free care and the hospital's policy for providing it. Specifically:

- Three telephone inquiries were made to each hospital's general information number, on different days and at different times, by each of the uninsured surveyors asking whether the hospital provided free care and, if so, what its policy was for making it available.
- Two telephone inquiries were made to each hospital's general information number by social service agency staff that identified themselves and asked the same questions about availability of free care on behalf of the clients their agencies serve.
- One on-site visit was made to each hospital by a faith-based volunteer who examined the premises for signs indicating the availability of free care and identified her/himself to staff to ask about free care.

Some of the uninsured surveyors attempted to ask their questions in Spanish or Haitian Creole.

To ensure uniformity, the surveyors used a telephone protocol and a site visit protocol. They then recorded the results on forms provided to them. Upon completion of the survey, surveyors also attended a verbal debriefing session to share their experiences and make recommendations based on those experiences.

In all, 47 calls were placed and eight on-site visits were made to the seven hospitals listed above.

KEY FINDINGS

- At none of the seven hospitals did staff consistently inform surveyors that free care was available to low income, uninsured individuals.
- At four hospitals, some surveyors were told that free care was available, while others were told that free care was **unavailable** to uninsured, low-income individuals. (At the three remaining hospitals, staff consistently informed surveyors that no free care was available.)
- Of the four hospitals in which one or more staff reported free care policies, only **one** provided a written free care policy upon request.
  - One hospital refused to send their free care policy.
  - One hospital sent a copy of their mission statement in lieu of a free care policy.
  - One hospital sent information on income eligibility and required documentation for *financial aid*, but not for free care.
- Uninsured surveyors had a much harder time obtaining responses to their questions than surveyors calling from community agencies or faith-based organizations. Moreover, nearly half the uninsured surveyors reported being treated rudely and **no** uninsured surveyor reported s/he would be comfortable seeking service at the hospital called.
- Only at two of the seven hospitals were any of the non-English speaking surveyors able to have their questions answered.
- Staff at the general information telephone number, for the most part, did not know who could give surveyors information on free care.
- At most hospitals, staff in the billing department did not know if free care was available
- Nearly one fourth (23%) of the calls made by uninsured surveyors were met with a refusal to answer questions on free care, or even to refer the questions to anyone else at the hospital
- Most surveyors were transferred several times from one staff member to another.

One surveyor was told, ***Either you have to go to Medicaid or to Catholic Charities.***

At one hospital, a surveyor speaking to a staff member in patient accounts was told, ***Free care does not exist here. If they need free care they should call and go to the County Medical Center.***

One surveyor asked, ***If someone came into your hospital and needed healthcare and had no insurance, would you serve them?*** and was told, ***No, I don't believe so. This is a private clinic and they cannot take any patient who cannot pay.***

- Some surveyors were kept waiting on the phone for such a long time that they hung up.
- Several surveyors were told to go elsewhere for free care. They were referred to community outreach programs, county clinics or the former county hospital.
- Surveyors were generally told that emergency care would be provided (as required by federal law), but that the patient would be billed for services.

Selected findings and observations for each of the hospitals in the survey are as follows:

GOOD SAMARITAN HOSPITAL MEDICAL CENTER

- Three of four people who surveyed the hospital were told about a limited free care program. A fourth surveyor was not informed of the program.
- No written free care policy was provided and no policy was posted.
- Only English speaking surveyors were able to obtain information. Non-English speaking calls were placed, but no information on free care could be obtained.
- Surveyors were transferred a lot or had very long waits, but were treated politely.
- Based on their experience, uninsured surveyors said they would not seek care at this hospital.

HUNTINGTON HOSPITAL

- Only one staff member indicated that free care was available. No signs were posted.
- Information was obtained on two of the non-English speaking calls placed, but no information could be obtained on a third.
- Surveyors were transferred a lot or had very long waits and, in some cases, were treated rudely.
- Most surveyors were referred to the hospital's community clinic, which indicated only that a reduced fee might be arranged.
- Based on their experience, uninsured surveyors said they would not seek care at this hospital.

LONG BEACH MEDICAL CENTER

- Some, but not all, surveyors were provided information about free care, while others were not informed of the program.

- The written policy provided indicated a sliding fee scale was available but not free care.
- Surveyors were transferred a lot or had long waits.
- Signs were posted indicating that no one is refused service due to an inability to pay.
- A non-English speaking surveyor was able to obtain information about a sliding fee scale consistent with the information obtained by English speaking surveyors.
- Based on their experience, uninsured surveyors said they would not seek care at this hospital.

MERCY MEDICAL CENTER

- Only one out of the over thirty individuals to whom surveyors were connected indicated that the hospital provided free care.
- Though a written free care policy was promised, only a mission statement was sent to the surveyor.
- Surveyors were transferred a lot or had long waits and some were treated rudely.
- No signs were posted related to the availability of free care, but the mission statement indicating that the hospital provides "service to all based on need not ability to pay" was posted in the lobby.
- Only English speaking surveyors were able to obtain information. Non-English speaking calls were placed, but no information on free care could be obtained.
- Based on their experience, uninsured surveyors said they would not seek care at this hospital.

NASSAU UNIVERSITY MEDICAL CENTER
(FORMERLY NASSAU COUNTY MEDICAL CENTER)

- Surveyors were consistently told that free care was unavailable, and no policy was posted. In some cases, they were told that reduced rates are available to county residents. (See footnote number ten on page ten.)
- Material on payment plans, but not free care, was made available to a surveyor.
- Surveyors were transferred a lot or had long waits and some were treated rudely.
- Only English speaking surveyors were able to obtain information. Non-English speaking calls were placed, but no information on free care could be obtained.
- Based on their experience, uninsured surveyors said they would not seek care at this hospital.

NORTH SHORE UNIVERSITY HOSPITAL

- All surveyors were told that there was no free care; no policy was posted.
- Surveyors were transferred a lot and had long waits and some were treated rudely.
- Only English speaking surveyors were able to obtain information. Non-English speaking calls were placed, but no information on free care could be obtained.
- Based on their experience, uninsured surveyors said they would not seek care at this hospital.

WINTHROP UNIVERSITY HOSPITAL

- Winthrop Hospital is required by the federal Hill Burton program[9] to provide free care as a condition of receiving program funds.
- Some surveyors were told free care was available and were able to obtain a written policy indicating that free care was available, while others were not able to obtain any of this information.
- A sign was posted in the Admitting Department indicating that free care is available; written notices were also present.
- Surveyors were transferred a lot or had long waits and some were treated rudely.
- Only English speaking surveyors were able to obtain information. In only one non-English speaking call (placed to accounting) could free care information be obtained.
- Based on their experience, uninsured surveyors said they would not seek care at this hospital.

FREE CARE RECOMMENDATIONS

The purpose of this survey was to determine if hospitals have explicit free care policies and whether that information is readily available to consumers and those representing consumers. The survey results indicate that information about free care is nearly non-existent and extremely difficult to obtain, especially for the uninsured themselves.

Because free care is an essential part of the health care safety net, it is important that it is made available and that the community knows about its availability. A number of steps should be taken by responsible authorities and by the hospitals themselves to ensure that present obligations are being met. In addition, some regulatory changes should be made to strengthen the free care system. Based largely

[9] The federal Hill Burton program (which provided construction funds to nonprofit and public hospitals) obligated facilities to provide free or reduced cost medical services to those persons who are uninsured or underinsured, and meet eligibility criteria. See http://www.hrsa.gov:80/osp/dfcr/about/aboutdiv.htm for more information.

on suggestions of the project's advisory board and the surveyors, the Coalition recommends that:

Hospitals:

- (In the absence of state guidelines) provide free care to uninsured individuals with incomes below 150% of the federal poverty level ($12,885 for an individual, in FY2001.)
- Adopt uniform free care policies and prominently display policies in order to inform patients.
- Include all applicable fees and services when providing free care.
- Train staff to provide accurate, consistent information about free care to patients.
- Not bill individuals applying for free care until an eligibility determination is made.
- Make available information about free care in a culturally competent manner in those languages that are common in the area.
- Work with local communities through advisory boards representative of the community in order to develop and implement free care policies and practices.
- Make every effort to help low income patients apply for assistance programs for which they may qualify—such as Catastrophic Health Care Expense Program (CHCEP[10]), Medicaid, Child Health Plus and Epic—before billing those ineligible for free care.

Government Agencies:

- Develop minimal requirements for hospitals' provision of free care and actively monitor compliance.
- Make hospitals' eligibility for public monies dependent on their delivery of charity care by establishing an expected proportion of gross revenues devoted to charity care, monitoring compliance and applying penalties when appropriate.

Community:

- Work closely with local hospitals to craft new free care policies that are responsive to the needs of the community.
- Publicize the availability of free care and remain involved by monitoring and reporting hospital compliance in the provision of free care.
- Participate in hospital advisory boards.

---

[10] CHCEP, a state program designed to cover catastrophic health expenses, is being piloted in four counties, including Nassau, but not Suffolk. Based on income and resources, participants are billed on a sliding scale that goes down to zero for those most in need. Only one surveyor reported being informed about this program.

METHODOLOGY

During the early part of 2000, the Long Island Health Access Monitoring Project contacted seven hospitals in Nassau and Suffolk Counties in order to request the hospitals':

- Mission statement
- Most recent community service plan
- Cost of charity care for the most recent year

It was hoped that by reviewing these documents—required by statute[11]—community members could assess the hospitals' commitment to community benefits and free care in the communities they serve. The reports were also expected to describe the involvement of community members in identifying needs and setting priorities for community benefits programs.

The hospitals included in this study provided some of the requested information. An FOIA request was filed with the New York State Department of Health, Bureau of Hospital and Primary Care Services. Upon receipt of the available information, Linda Wenze, Associate Professor for the Department of Health Care and Public Administration at Long Island University, C.W. Post Campus, conducted a review of the reports in order to analyze the community benefits and charity care provided, as well as the hospitals' processes of involving the community in assessing priority needs.

KEY FINDINGS

1) **Mission Statements.** The Health Care Reform Act requires governing bodies of nonprofit hospitals to issue a mission statement identifying, at a minimum, the populations and communities the hospital serves and the hospital's commitment to meeting the health care needs of the community. In addition, nonprofit hospitals must review their mission statements every three years and amend them as necessary.

   - Although all seven hospitals have submitted mission statements to the Department of Health, little detail was provided on the "populations and communities" served. Several hospitals simply included a list of cities and towns in their service area. One hospital only reported serving "residents of Nassau County." Two others simply referred to "the communities served" in their mission statements but did not identify these communities. Without more specific information, it is difficult to assess whether hospitals are meeting the needs of populations and communities in the surrounding area.
   - As evidence of their commitment to meeting the health needs of the community, several of the mission statements stated the hospitals serve all patients regardless of "ability to pay;" others reported they serve all

[11] Codified as N.Y. Pub. Health Law § 2803-1 (known as the "Health Care Reform Act").

patients regardless of factors such as race, color, religion, age, sex, and disability. One included only an affirmation that it will "meet the health needs" of residents and another hospital simply pledged to respond to "the changing health care needs of the community."

2) **Soliciting Community Views**. Every three years nonprofit hospitals must solicit the communities' views on such issues as hospital performance and service priorities and demonstrate the hospital's operational commitment to meeting community health care needs.

    - Three hospitals described a variety of methods for obtaining community input on health services needs and priorities. None of these hospitals reported any of the actual findings derived from their community assessment or demonstrated how the findings were incorporated into hospital planning and decision-making.
    - Three hospitals reported only that they conduct a patient satisfaction survey, an activity that, while helpful, does not seem to fully satisfy the requirement to seek community views on hospital performance and priorities. (Two additional hospitals reported conducting satisfaction surveys in addition to other methods of seeking community views.)
    - One hospital reported that staff members participate in a "wide variety of groups in the community", which "keep[s them] current on the needs of a wide variety of constituencies" but did not describe its method for assessing staff observations. They also conduct a patient survey and described the process used to take action on patient comments.

3) **Financial Commitment to Charity Care and Access Initiatives.** Every three years, hospitals must report their financial commitment to meeting community health care needs, providing charity care and improving access to services for the underserved. They must also provide a public statement showing the financial resources of the hospital and the allocation of funds to free or reduced charge services.

    - None of the seven hospitals provided complete financial information related to free and charity care. In some cases, free care and bad debt were commingled; also, a number of the reports lacked information on overall hospital or systems resources, so the proportion of free care could not be determined.

4) **Every year, the hospitals must <u>make available to the public an implementation report regarding their performance</u> in meeting the health care needs of the community, providing charity care services, and improving access to health care services by the underserved.**

    - One hospital neither submitted a report to the state nor provided a report to researchers, while another hospital failed to provide a report to the state but did provide one to researchers.
    - Several hospitals listed activities that met health care needs and improved access for the underserved. Included were items such as: free

screening exams, taxi vouchers and meals for indigent persons, geriatric services, skin cancer and blood pressure screenings, low cost mammography and stroke assessment, and free flu and pneumonia vaccinations for seniors

- Some hospitals listed items whose classification as a community benefit was more questionable, such as training and educating nutritionists and food service workers, providing opportunities for high school students to learn about health careers, providing a special catheter to a person in Peru, educating visiting physicians from abroad, supervision of college students, maintaining a Human Research committee, and participating in a parade.
- Some hospitals described needs assessment tools they used, but few provided any analysis of the findings and none specified how the findings were used in planning and decision-making.
- No report from any hospital indicated the progress made in implementing community benefits identified in the previous year's report.

DISCUSSION

Analysis of the materials made available concerning the seven hospitals provided a great deal of insight into the approaches taken by facilities in complying with state requirements. The materials were often difficult to obtain. Also, the materials were frequently organized in a manner that made them hard to review, hard to understand, and hard to compare to the requirements articulated by the state. In addition, a number of facilities do not appear to have fully complied with the state requirements for filing information; one hospital had no Community Service Plan available through the state. Others do not appear to have filed adequate financial information.

The state requirements were often ambiguous or confusing, making it unclear whether specific activities or programs met the intent of the law. For example, the state's unreimbursed care pool is named the General Hospital Indigent Care Pool, and is commonly referred to as the "free care/bad debt pool." This may partially explain why the hospitals often failed to differentiate between free care and bad debt when making submissions related to community benefits, even though the Community Benefits Law requires this.

Similarly, the law requires that the mission statement must identify the populations and communities the hospital serves, but does not describe what it means by these terms. Hence, hospitals use very general geographical terms ("serve the needs of Nassau County residents," or "our neighbors in Southwestern Suffolk County"), and rarely analyze any data related to the community.

Further, while the mission statement must include the hospital's commitment to meeting the health care needs of the community, there is no corollary requirement to assess, evaluate, or analyze any data about the community. Therefore, many hospitals state that they are committed to meeting the health care needs of the community, but demonstrate no method for determining what those needs are or how they should best be met.

There is also a lack of clarity about the state's expectations with regard to the requirement to demonstrate financial and operational commitment to charity care services and improving access to health services for the underserved. Thus, there is a wide range of responses to this item.

Hospitals include long lists of activities in their reports, many of which do not specifically fulfill any of the requirements listed in this report. This seems to reflect a lack of clarity on their parts as to the intent of the state's requirements; as a result, hospitals include any items that may show community service, charity care, and commitment to the community, etc.

Finally, the State requires that the hospital solicit the views of the communities the hospital serves on issues such as the hospital's performance and service priorities. Most hospitals collect patient satisfaction data: how hospitals incorporate this information into decision-making, however, is unclear. With reference to service priorities, there appears to be very little effort put forth by the hospitals to collect this data. And, again, there are almost no descriptions of how, or if, community input is used.

HOSPITAL COMMUNITY BENEFITS RECOMMENDATIONS

In order to promote hospital community benefits programs and increase community involvement in determining priorities for these services, we recommend that:

Hospitals:

- Institute advisory boards composed of representatives from a cross-section of the service area's population. The boards should provide input regarding needed community services.
- Employ additional methods, such as public meetings, surveys or interviews, to obtain community input and use this input to craft community benefits programs.
- Publicize and post the availability of charity care, including what services are covered.
- Publicize and post implementation reports detailing changes made to services/ community benefits resulting from recommendations made by community representatives, as well as progress towards previous years' identified objectives.

Government Agencies:

- Be more specific about the documentation hospitals should submit in order to meet requirements of the community benefits statute. For example, what information is needed to identify the hospital's "operational and financial commitment to meeting the health care needs of the community?"
- Develop a consistent reporting format. As presently prepared by the hospitals, the reports are quite different and, often, hard to follow. Many of the reports include pages of information that do not address any of the requirements, and may fail to include the information actually sought by the state.

- Contact hospitals that do not file information to assure that submissions are made. Apply a financial penalty if a hospital does not provide the required information.
- Review the reports and hold hospitals accountable for proposed activities. Currently, we have no way of knowing if reports are reviewed in order to determine whether or not hospitals have implemented programs proposed in previous years.

Community:

- Participate in advisory boards.
- Engage and inform the community about hospital community benefits.
- Monitor hospital community benefits activities and reporting.