HOLEs IN THE SAFETY NET:
An Examination of Hospital Charity Care Access on Long Island

By Trilby deJung and Don Friedman
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Acknowledgements
This report is gratefully dedicated to Rose Guercia and the late Donna Kass, Long Island’s tireless advocates for a just and comprehensive public health system, who coached us in this effort and who paved the way with an earlier study of compliance with local charity care laws.

Special thanks to the Touro Law Center, which has for nearly five years provided a home to the Long Island office of the Empire Justice Center, and whose students did much of the on-the-ground work to conduct this survey with visits and calls to twenty-three hospitals on the Island.

Special thanks also to Dannis Matteson, who generously volunteered her time to help us compile, organize and make sense of the data we had collected, and David Silverman, who scoured the Hospital Financial Assistance Law and created a review of its requirements to guide the survey.

The Survey Was Conducted By: Myra Breitburg, Jennifer Bristol, Nikita Dow, Jesseka Green, Helen Harrington, Fareeha Malik, Krista Pisciotto, Molly Roush, Emily Small

About Empire Justice Center
Empire Justice Center is a statewide, public interest law firm with offices in Albany, Rochester, White Plains and on Long Island. Empire Justice focuses on changing the “systems” within which poor and low-income families live. With a focus on poverty law, Empire Justice undertakes research and training, acts as an informational clearinghouse, and provides litigation backup to local legal services programs and community based organizations. As an advocacy organization, Empire Justice engages in legislative and administrative advocacy on behalf of those impacted by poverty and discrimination. As a non-profit law firm, Empire Justice provides legal assistance to those in need and undertakes impact litigation in order to protect and defend the rights of disenfranchised New Yorkers.
For years, New York State provided financial support to hospitals to help cover their “bad debts and charity care.” Hospitals, the reasoning went, must provide care to anyone presenting with a potential emergency regardless of their ability to pay. In order to help pay for this uncompensated care, New York created the Bad Debt and Charity Care funding pools through which hospitals were compensated for this uncovered care.

Unfortunately, in creating the system, the state developed an accounting formula that had no relation to the actual care provided to individual patients. Early on, hospitals were also found to be billing patients for care even when the costs were underwritten by the state, and were then using aggressive debt collection practices to collect from the low-income, uninsured patients.

This inconsistency in the payments hospitals received and the financial support they provided to patients was finally addressed in 2006 with the New York’s Hospital Financial Assistance Law (HFAL).

HFAL obligated hospitals to offer financial assistance with emergency care and non-emergency care to qualified low-income patients as a condition of receiving state funding for charity care. Hospitals were required to:

- Adopt written financial assistance policies for both emergency and non-emergency care;
- Make information about those policies available to the public; and
- Provide patients with assistance in applying for financial aid.

Is The Charity Care Safety Net Working?

The goal of this report is to provide a consumer perspective on whether HFAL has been effective in helping individuals and families access non-emergent care and thus prevent medical emergencies and help avoid financial crisis. For the report, Empire Justice Center examined whether or not hospital staff are providing prospective patients with the information they need to access the financial aid that should be available to them; and the extent to which hospital staff are providing the assistance envisioned under the 2006 statutory changes.

Our data, drawn from experiences with hospitals on Long Island, indicates that 49% of hospitals fail to provide family members of seriously ill, uninsured patients with the information they need to get financial assistance in advance of a medical emergency. Thirty-five percent (35%) of hospitals surveyed were able to provide the necessary information either over the phone or in person, but not both. Only 17% of the hospitals surveyed provided accurate and helpful information both in person and over the phone. Clearly, deeper changes are needed to ensure that HFAL helps families prevent medical and fiscal crisis.
Failure to Improve Could Drive Federal Losses

Impending changes in federal policy only add to the sense of urgency. Today New York receives over $1.6 billion in federal Disproportional Share Funding for Hospitals (DSH), from which it funds the Indigent Care Pool. This level of federal funding will not continue. Under the federal Affordable Care Act (ACA), fewer federal dollars will be available to help states finance hospital charity care as fewer Americans are expected to be uninsured.

New York will need to have credible data on the state’s ability to target DSH dollars to hospitals that provide a high volume of service to Medicaid and uninsured patients in order to maximize the state’s share of the federal funding that remains. Current methodologies are out of step with federal regulations and fail to provide the accountability and tracking that will drive federal allocations in the future. If New York does not improve the targeting of its Indigent Care Pool dollars to hospitals that are providing high levels of uncompensated care, the state will not be able to demonstrate the competitive need that will drive allocations from a shrinking pool of federal contributions.

BACKGROUND

New York’s commitment to maintaining eligibility and benefit levels for public insurance programs has helped counteract the national trend toward rising uninsured rates as employer-sponsored insurance continues to decline. However, according to newly adjusted data from the Census Bureau, over 2.8 million New Yorkers remain uninsured. According to the United Hospital Fund, over one million of New York’s uninsured live in families with at least one full-time worker. The highest uninsured rates are found among low-income families, young adults, Hispanics, and non-citizens.

Federal health care reform promises to bring affordable health coverage to many uninsured New Yorkers. Experts estimate that up to 1.2 million New Yorkers could gain coverage through a State Health Insurance Exchange. However, that means that between 1.4 and 1.8 million could remain uninsured. Clinics providing free or reduced cost care to the uninsured play a critical role in providing primary and preventive care in high need communities, but hospitals remain the major source of health care for uninsured people with serious medical conditions.

In recognition of the financial burden charity care places on hospitals, New York uses state and federal Medicaid funds to underwrite the costs of hospital services for the uninsured. Initially created as a bad debt and charity care pool in 1983, the source of this critical funding was renamed the Indigent Care Pool under the Health Care Reform Act (HCRA) of 1996. HCRA deregulated rate setting in New York while maintaining funding for “public goods,” including charity care for uninsured and underinsured patients.

By 1993, distributions from the Indigent Care Pool represented the largest expense in HCRA and amounted to almost $850 million. While some states, including Massachusetts and New Jersey, required hospitals to document care provided to uninsured patients in order
to access funding from their state’s charity care pool, New York had no such requirement. Instead, money was allocated from several distinct “pools” on the basis of a complicated accounting methodology intended to provide an assessment of a hospital’s level of expense related to uninsured care and bad debt.

Patient advocacy groups conducted several influential studies in the 1990s criticizing hospital charity care performance. In 2003, the Wall Street Journal published a series of articles which received widespread attention chronicling the experiences of low-income New Yorkers hopelessly mired in hospital debt and aggressively pursued by collection agencies.

In 2006, Empire Justice publicized the findings of its survey of bankruptcy clinics in upstate New York. The report, In Sickness and in Debt, surveyed consumers at free or low-cost legal clinics in Albany, Syracuse, Rochester and Buffalo, asking respondents whether they had unpaid medical bills from any sources, including hospitals, doctors, pharmacies and ambulance services. Over half (58%) of the people who sought help from bankruptcy clinics and responded to the survey were struggling with medical debt. The majority of those reporting medical debt had delayed seeking care. Eighty percent (80%) of those with medical debt ended up owing money to hospitals.

In that same year, New York newspapers exploded with the story of a young man named Manny Lanza. Manny worked at a fast food restaurant which offered no health insurance coverage. He was diagnosed with a serious brain condition, but was denied Medicaid coverage. As an uninsured prospective patient not yet facing an emergency, Manny Lanza was not entitled to emergency care or hospital financial assistance for non-emergency services. He died two years later of a ruptured blood vessel in his brain after a procedure to reduce swelling was postponed for months by his hospital.
Legal reforms finally took place with the passage of the Hospital Financial Assistance Law (HFAL), also known as “Manny’s Law,” in 2006. Under HFAL, hospitals in New York are required to provide financial assistance to low-income uninsured patients on a sliding scale, publicize information about their policies, and refrain from egregious debt collection practices. The requirements of Manny’s Law apply not only to emergency care, but also to medically necessary non-emergent care for persons residing within hospitals’ primary service area.\(^\text{10}\) While hospitals can require patients who might be Medicaid eligible to apply for Medicaid, they cannot refuse to process an application for financial assistance while the Medicaid application is pending.\(^\text{11}\)

The State Department of Health (SDOH) initially devoted significant agency resources to implementing HFAL. SDOH met with hospitals and patient advocates to hammer out definitions of primary service areas and to provide detailed guidance on statutory requirements for notification and application procedures. HFAL stopped short of changing the state’s method for distributing funding from the Indigent Care Pool, however, and the state has not devoted significant resources to enforcement or compliance monitoring.

In 2008, SDOH convened a Technical Advisory Committee to review the hospital charity care system. The Committee conducted several hearings around the state and received regular briefings from Health Department staff. In the end, the Committee concluded that the accounting formulas used by hospitals were problematic and that the data that hospitals reported reflected high levels of unexplained and implausible variability.\(^\text{12}\)

The Committee recommended that units of service for patients eligible for financial aid be used as the primary basis for establishing annual award levels from the Indigent Care Pool. The Legislature responded by restructuring the formula accordingly, but for only 10% of the total distributions from the pool.

Even this modest restructuring has enhanced data collection, however. Two separate analyses subsequently demonstrated what many suspected to be true -- some hospitals are overpaid while others are underpaid.\(^\text{13}\)

In a paper released in August 2011 by the Commission on the Public’s Health System, Professor Alan Sager compared current hospital allocations from the Indigent Care Pool to dollar figures representing uncompensated care actually provided and found that a number of hospitals are paid large sums even though they apparently provide very little uncompensated care. Dr. Sager concluded that the current methods of allocating scarce funding for uncompensated care fail to compensate hospitals “in fair relation to their efforts.”\(^\text{14}\)

A study by the Community Service Society (CSS) similarly concluded that public hospitals, which provide the most financial assistance, get the least amount of indigent care funds. CSS reported that many of the hospitals reporting the highest targeted need (an accounting measure used to determine award size for current Indigent Care funding) also reported lower than average financial assistance relative to their size.\(^\text{15}\)
What is it like to try to find medical care for a friend or family member who is uninsured?

We sought to answer this question, to the extent possible, by putting our researchers in the shoes of a family member of an uninsured person with a serious medical condition. We decided to focus on non-emergency care because these services are so critical for preventing emergencies, both medical, like the brain condition that killed Manny Lanza, and financial, like the bankruptcies that we collected data on in 2005 and continue to hear about today. Given the lack of incentives for hospitals to enroll patients in their financial assistance programs, we questioned whether hospitals were prepared to provide assistance to family members in advance of an emergency.

**A Survey of 23 Hospitals on Long Island**

Empire Justice gathered data from 23 hospitals on Long Island using law student researchers as “secret shoppers.” Student researchers presented themselves as proactive family members seeking to learn about how to access non-emergent, preventive care. They approached hospitals in person and over the phone, posing as the daughters or sons of seriously ill, uninsured parents and asking about the options for financial assistance with medically necessary care in advance of a medical emergency. The survey included a combination of subjective descriptions of encounters as well as objective recordings of visual data and paperwork that was (or was not) provided by hospitals. A description of the survey and the data we collected is attached as Appendix A.

As with any survey of this kind, there are significant limitations to the data. Since different researchers visited different hospitals, it is likely that there were differences in the tone of requests made and the amount of detail provided regarding the family’s purported situation. The findings are presented not as a statistically valid study, but as a snapshot of the information low-income family members on Long Island are likely to gather from their local hospitals.

The details that emerge from the survey provide an important perspective on the effectiveness of HFAL in helping families prevent the crush of medical debt. The report concludes that family members of a seriously ill uninsured person will find it all but impossible to access financial assistance in advance of an emergency at almost half of the hospitals surveyed.
At approximately 17% of the hospitals surveyed, researchers received enough information both on the phone and during walk-in visits to enable them to successfully apply for financial assistance for a family member in advance of an emergency. Approximately 35% of the hospitals offered clear information either on the phone or in person, but not both. But at approximately 49% of the hospitals, students found it virtually impossible – whether in person or by phone – to access accurate information about financial assistance in advance of an emergency.

**Four Hospitals Earn a “Good” Rating (17% of those surveyed)**

Experiences with four hospitals (hospitals C, D, M and W) were classified as “Good.” These four hospitals provided the guidance family members would need to apply for Charity Care, both when they called in and when they visited in person. One hospital offers an example of best practices. Upon walking in to hospital C, consumers can easily spot a sign informing patients of Charity Care in Spanish and English. The front desk immediately referred the student who asked about care for her chronically ill mother to personnel in the billing department where she received a financial aid application to take home and was given instructions on how to fill it out. The phone call was just as informative. The operator provided the name and number of someone who was available to meet with the student and provide guidance.

Other hospitals in the “good” category were not quite as helpful as Hospital C but students were ultimately given enough information to make applying for financial assistance possible. For example, in Hospital D, neither of two desk clerks the student approached was able to answer any questions about eligibility for financial assistance, but one did hand the student a page of information with an application form on the reverse. The other directed her across the street, where, after a long wait, some questions were answered. At Hospital M, the student encountered desk attendants who were unfamiliar with financial assistance and had to wait for clerks to find informed personnel. The experience at Hospital W included a private conversation with a staff member and assurances that her mother would receive help with her medical bills.

For each of the hospitals with the most favorable rating, phone calls were also productive. In all cases, the caller was either provided sufficient information about charity care during the course of the conversation, was directed to an informative website or was offered, and soon received, information by regular mail. Overall, although perseverance was sometimes required, those surveying these four hospitals were ultimately provided the information necessary to access financial assistance in advance of an emergency.
Experiences with Eight Hospitals are Classified as “Mixed” (35% of those surveyed)

Many of the hospitals surveyed were rated “Mixed.” This group posed a challenge for the evaluation process by demonstrating a marked discrepancy in their responses. At these hospitals, those conducting the survey generally found one point of access to be effective and informative, but found others to be inaccurate or simply lacking in information. For example, Hospital F provided clear instructions over the phone, but failed to provide information in person. The hospital neglected to post a visible sign for patients to read upon walking in and the desk clerks were not able to direct the students to information about financial assistance. At Hospital H, the students who walked into the hospital were met by desk attendants who spoke knowledgably about financial assistance and provided instructions for applying. However, a phone request for information was unsuccessful; the student was inappropriately advised that her mother should apply for Family Health Plus instead.

While perhaps the most common shortcoming for these hospitals was a failure to provide information about charity care, in a number of instances, misleading information or advice was provided. This included Hospitals G and H, where students were advised that their mother needed to apply for other public benefits, Hospitals E and O, where the students were told that a charity care application could only be provided following a hospital admission and treatment, and Hospital T, where the student was advised to pursue church charities. In addition, for Hospitals J, Q and U, the student was never able to reach someone with whom to discuss the issue, despite repeated efforts.

Experiences with Eleven Hospitals are Classified as “Poor” (49% of those surveyed)

Eleven hospitals, almost half of those surveyed, were rated “Poor.” For each of these hospitals, those conducting the survey found it impossible to gain information about financial assistance, either through phone or walk-in visits. Their experiences replicated the negative elements of the “Mixed” category, but without the occasional positive features of the Mixed category hospitals. Students, whether in person or by phone, were repeatedly told by staff at Hospitals E, I, L, N and U, that charity care could only be discussed or applied for following treatment or an emergency admission. The student’s questions prompted confusion on the part of hospital staff, which often provided them with inappropriate referrals, either to other programs, such as Family Health Plus, Medicaid or the NY Bridge Plan, or to other providers, such as clinics, church charities or the county.

Students visiting many of these hospitals reported speaking with hospital workers who apparently had no knowledge whatsoever of the existence of a charity care policy in their hospital (Hospitals A, J, L, P, R, T). Telephone inquiries frequently led to multiple, ultimately
futile transfers (Hospitals I, J and R), or no response whatsoever, even when students left multiple voice mail messages (Hospitals J and U). In six cases, after repeated attempts to learn about their options, students were simply turned away with no information at all (Hospitals J, L, P, Q, R and U).

While the students were, in their preparation for the survey, advised not to take extraordinary action to obtain information, they were primarily well-educated graduate students, and were undoubtedly more persistent and better able to articulate their concerns than would be the case for many of the individuals eligible for charity care. That their efforts were, in many instances, so unsuccessful, suggests an even more challenging experience for the more typical low-income person, with limited education, perhaps limited English proficiency, and undergoing the stress of managing serious medical needs for an uninsured family member.

What does this tell us?

The snapshot of consumer experience provided by the survey sheds important light on the barriers low-income New Yorkers are likely to experience if they approach their local hospital for help with a seriously ill, uninsured family member. The findings also highlight significant variance in responses to the Hospital Financial Assistance Law among hospitals on Long Island.

The most fundamental conclusion we draw from the data, however, is that far too many low-income, uninsured New Yorkers are likely being denied access to help with paying for non-emergent care at hospitals. Even the hospitals ranking in this “mixed” category represent a large gap in access since half the time; inquiries at these hospitals were met with incorrect information or no information at all.

The results of the survey are not surprising given the current financial structures that fail to provide incentives for hospitals to enroll patients in their financial assistance programs. Although almost all of New York’s hospitals are nonprofit organizations, and many are mission-driven to provide care to low-income patients, this survey indicates that only a minority prioritize publicizing and educating patients about the availability of financial assistance in advance of an emergency admission.

The findings regarding staff confusion about the availability of financial assistance in advance of an emergency indicates that hospitals have done a better job internalizing their responsibility for providing help with emergency care than they have for understanding their responsibility for providing help with non-emergent care. It is ironic that financial assistance with non-emergent care may be receiving less attention from hospitals, given the wide-spread recognition of the need to reduce hospital admissions and stabilize chronic conditions.

It may be that one of the factors at play here is a bias within the Hospital Financial Assistance Law itself, which was after all, a response at least in part to media attention to debt
collection practices following medical emergencies. While most of the provisions in the law address emergency settings, the law does require hospitals to provide financial assistance with medically necessary care outside of emergency rooms for residents of the hospital’s primary service area. In the end, Manny Lanza died because he could not schedule preventive surgery for his brain condition, not because he couldn’t pay his emergency room bill.

Hospital charity care expenses will continue to be a significant burden for both hospitals and New York State in the years to come. This is particularly true since reductions in federal funding for charity care in New York may outstrip the ongoing need. Since reform to New York’s distribution methodologies are needed in order to ensure that New York is eligible for the maximum amount of federal funds that will remain, now is the time to adjust incentives to maximize hospital compliance with HFAL requirements for both emergent and non-emergent care.

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<th>Visual indication that the program exists (Sign)(2)</th>
<th>Patient was given or mailed application if s/he was there in person (1)</th>
<th>Patient was given other eligibility material (in form of brochure, etc)(2)</th>
<th>Patient was able to contact a thoroughly informed point person while there in person (2)</th>
<th>IN PERSON Score: (7= best)</th>
<th>Caller experienced 2 or fewer transfers (1)</th>
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CONCLUSION & RECOMMENDATIONS:

The findings in this report illustrate the reality behind HFAL – hospital compliance is uneven and patient experience is mixed. More state resources are needed for monitoring and enforcement, and more is needed in the way of driving the financing of charity care to ensure that prospective patients are fully informed about the options for financial assistance.

The disparity and the barriers that emerged in this study show that New York’s state-mandated financial assistance program is not reaching many of the patients the law was intended to benefit, particularly when care is needed in advance of an emergency.

Thus we make the following recommendations for reform in New York’s charity care system:

1. **Enforce the Hospital Financial Assistance Law.** NYSDOH must be required to oversee and report on audits for compliance with HFAL, either through the Office of the Medicaid Inspector General or through an independent, third-party auditor. Penalties must be assessed and funding withheld as a consequence for non-compliance.

2. **Address Barriers to Applying for Financial Assistance.** NYSDOH must do what it can to make the process of applying for hospital financial assistance more consistent and accessible, including:
   1) Publicizing hospital financial assistance policies in all centralized locations (waiting rooms, billing offices, website);
   2) Highlighting the availability of financial assistance for non-emergency care; and
   3) Standardizing the application for financial assistance and the documentation that can be required by hospitals to verify information on the application.

3. **Link payments to patients.** Funding methodologies should be developed that link indigent care payments to services actually delivered to low-income, uninsured patients receiving financial assistance. Any methodologies must ensure that low-income uninsured patients included in data counts are not subjected to collection activities.

4. **Target scarce resources appropriately.** Indigent Care Pool distribution methodologies must be revised immediately to ensure that scarce funding for uncompensated care is not unfairly allocated to hospitals that provide very little charity care or financial assistance to consumers. New York must target federal funds to hospitals that are providing high levels of care to low-income, uninsured patients.

  With the successful implementation of these reforms, New York will move toward a stronger health care Safety Net for its most vulnerable citizens.
1 DSH payments to states were created by Congress in recognition of the need for states to support hospitals serving a disproportional share of low-income patients when designing Medicaid payment systems. State payments to hospitals servicing high numbers of the low-income are supplemented by a 50% match from the federal government. For amounts received by state, see “Federal Medicaid Disproportionate Share Hospital (DSH) Allotments,” Kaiser State Health Facts, Web, Kaiser, January 2012.
2 Health Care and Education Reconciliation Act of 2010, § 1203.
10 Public Health Law § 2807-k(9-a).
11 Ibid.
14 Sager, A. Paying New York State Hospitals More Fairly for their Care to Uninsured Patients, The Commission on the Public’s Health System, August 2011.
APPENDIX A:

Data Collection

This research was conducted in the form of a “secret shopper” survey beginning in the summer of 2010 and concluding in the spring of 2011. A group of law students made three contacts with each of Long Island’s 23 hospitals, one in person and two by phone. By completion of the survey, 69 overall hospital contacts had been made, providing a front-line snapshot of what uninsured, low-income visitors and callers would likely experience.

For both the in-person visits and the telephone contacts, the student presented herself as the daughter of a woman who lived in the vicinity of the hospital, who had been advised by the local Department of Social Services that she was not eligible for Medicaid, generally because of a failure to fully document her immigration status, and who did not qualify for Medicare. The student would also state that her mother suffered from a condition, such as diabetes, that was under control at the moment, but was subject to sudden changes that might well require hospital care. Thus, the scenario described suggested a condition that might require emergency care, but that more likely would call for out-patient treatment at a hospital clinic or perhaps a scheduled admission for in-patient care.

For each hospital, an initial visit was made to the hospital, checking first to verify that appropriate signs were posted advising people generally of the potential availability of financial assistance. The student would then speak with someone at the information desk or comparable site, depending on the hospital, describing her mother’s situation and asking for information about how to get help paying for necessary medical services. Students recorded the key elements of the interaction, the information that was provided verbally, any written information that was offered, and whether, upon request, further information was mailed. If the student was referred to another office within the hospital, she would go to that location and then report on that subsequent communication.

In addition to the in-person visits, each hospital was contacted by telephone on two separate occasions. The fact pattern was described on the phone and after the call was concluded, the student reported how long it took to reach a responsible, knowledgeable person, whether anyone was able to advise the caller about the possible availability of financial assistance, and whether the information provided was accurate.

Following each in-person and telephone contact, any anecdotal information about the quality of the interaction was reported, such as whether the interaction had been professional and courteous or otherwise. These more subjective descriptions enriched the understanding of the typical patient experience.

Once again, this report is not intended as an individual in-depth review of each hospital’s practices and procedures, but rather as a composite review to draw attention to a continuing systemic problem.
How the Data was Analyzed

To analyze the data we collected, criteria was established with which to evaluate the interaction with the hospital. The test applied in each case was whether the hospital provided enough information about financial assistance to enable the student to help her uninsured “mother” access non-emergent care.

Each criterion was assigned a score according to its relative importance in assisting the family member. If the hospital met a given criterion, the full score for that criterion was allotted. If the hospital did not meet the criterion, a zero was allotted. No partial scores were allotted for any criteria.

Criteria for assisting a family member visiting in person included:
1. The researcher was able to view a sign regarding financial assistance (score of 2);
2. The researcher was given or mailed an application (score of 1);
3. The researcher was given or mailed eligibility material such as a brochure (score of 2);
4. The researcher was able to speak with an informed staff-member (score of 2).

Criteria for successful assistance to a family member calling over the phone included:
1. The caller experienced two or fewer transfers (score of 1);
2. The caller was connected with an informed person during the call (score of 2);
3. The caller was mailed eligibility material such as a brochure (score of 2);
4. The caller was told how to apply (score of 2).

Scores for criteria in the in person category were added together for each hospital and a final number was assigned to represent the overall experience of a family member attempting to learn about financial assistance in person, the best possible experience adding to 7, the worst adding to 0. The same was done for the call-in category.

Each hospital was assigned a letter for reference to be uses in the report. The hospitals were then grouped into three basic ratings of consumer experiences: Good, Poor, and Mixed.

- Good experiences are those that have a 4 or higher in both in person and call-in categories.
- Poor experiences are characterized by hospitals that scored 3 or less in both categories.
- Mixed experiences are those that received a Good score in one category and a Poor score in the other.