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**A WELL-KEPT SECRET:**

**THE CHALLENGE OF FINDING OUT ABOUT  
HOSPITAL FREE CARE IN CLEVELAND, OHIO**

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**Universal Health Care Action Network of Ohio**

**October 2003**

**PREFACE**

**Universal Health Care Action Network of Ohio (UHCAN Ohio)** is a statewide organization working throughout Ohio for high quality, accessible, affordable, publicly accountable health care for all Ohioans. UHCAN Ohio strives to bring about health reform through education, grassroots organizing, and collaboration with individuals and organizations across Ohio on local and statewide policy change. Because of its concern for health care justice, UHCAN Ohio gives special attention to those most at risk in the present system. UHCAN Ohio has offices in Cleveland and Columbus.

UHCAN Ohio began its inquiry into the local health care safety net in 1998. In the summer of 2000, UHCAN Ohio and its community partners decided they wanted to learn more about free care policies at Columbus’s acute care hospitals. They wanted to determine how easy it would be for an uninsured person to find out about and obtain free care. They also wanted to determine if hospitals were complying with existing state free care laws and whether they were publicizing their own free care programs. With technical assistance from Community Catalyst, Inc., UHCAN Ohio members conducted the survey and developed the recommendations for the report, “Holes in the Safety Net: The Challenge of Finding and Getting Free Care at Columbus Hospitals” (available to [www.uhcanohio.org](http://www.uhcanohio.org)). That report led to a community/hospital collaboration which produced significant policy and practice changes (documented in “Mending the Safety Net,” available at [www.uhcanohio.org](http://www.uhcanohio.org)). Based on the success of the Columbus project, UHCAN Ohio decided to replicate this effort in Cleveland, with UHCAN Ohio’s members and community partners again conducting the survey and developing the recommendations. If you have any additional questions or would like to learn more about our work, please contact us at:

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**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.

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- Cindy Maxey, staff organizer, who recruited and trained callers and site visitors, and provided consistent oversight to ensure high quality results.
- The Callers and Site Visitors: Brenda Cheatham, Holly Cuffel, Flor Gomez, Nicole McGee, Mary Mihevic, Daphne McCaleb, Jim Paul, David Quintana, Mythili Sampathkumar, Rosalyn Scott, Janie Whitehead, and others. The callers made the telephone calls days and evenings as required. This often required multiple phone calls and navigating complex voice mail systems. The site visitors sometimes made multiple visits. Their thoroughness and tenacity made the project possible.

UHCAN Ohio would also like to thank the many Free Care Committee and Immigrant Health Access Coalition members who developed the recommendations, reviewed drafts of the report, and otherwise made the project successful. In addition to those listed above, we want to thank: Gail Bromley, Gail Long, Wendy Johnson, Mylion Waite, Louise McKinney, and others.

Cathy Levine, Executive Director of UHCAN Ohio, wrote this report, based, in part, on an earlier report co-written with Betsy Stoll and Jacquie Anderson, from Community Catalyst, and with assistance from Deborah Kleinman, policy director. Many thanks to Jacquie and Betsy for invaluable support and guidance.

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And a special thanks to Anne Hill, UHCAN Ohio's board president, for her tireless efforts on this project.

## EXECUTIVE SUMMARY

### Background

Free care—sometimes called “charity care” —is a critical part of the health care safety net. *Free care* is care provided by a hospital or other provider to low-income, uninsured people for which the provider does not expect to be paid. For people who have no health insurance and little money, free care is often the only way they can get necessary medical treatment. This report focuses primarily on the availability of hospital-based free care.

When free care is not available, people suffer significant health and financial consequences. People who can't afford care sometimes avoid seeking treatment until it's too late. And people who receive treatment but can't pay their medical bills often find themselves being chased by bill collectors whose efforts can lead to garnishment of wages, seizure of bank accounts, and the placement of liens on homes.

**The issue here is not whether the hospitals are providing care to the uninsured. Rather, it is that hospitals do not take steps necessary to inform patients and the public that free care is available and to enroll uninsured patients in free care or financial assistance programs.**

The need for free care is acute in Cleveland. In 2001, Cuyahoga County had an estimated 94,000 residents with no health insurance. Experts believe that number is growing, due to rising unemployment and the impact of rising health care costs on employer-sponsored coverage. Cleveland's uninsured residents need access to primary, specialty and hospital care that is free or discounted. Often, uninsured people with no place to go for primary care turn to hospitals for needed health care. Thus, hospitals are a vital part of the safety net for uninsured people.

The rate of uninsurance among racial and ethnic minorities – especially African Americans and Latinos – is higher than it is for non-minorities. In addition, the lack of established free care policies and practices shuts out minorities and may allow racial and ethnic bias of individual decision makers to influence who gets help and who doesn't. Thus, the absence of free care policies may contribute to racial and ethnic disparities in access to health care in our community.

Cleveland has a rising population of immigrants, refugees and other Limited English Proficiency (LEP) residents. Failure to provide language services, such as trained interpreters and translated signs and other written materials, prevents LEP patients from having meaningful access to either health care services or financial assistance.

In the 1990's, hospitals saw reductions in reimbursements from Medicaid, Medicare and managed care. At the same time, the demand for free care continued to climb. Cleveland's hospitals provide substantial health care services to uninsured patients: in 2001, Cleveland hospitals report that they provided \$113.7 million in

uncompensated care. But, the uncompensated care is not *free* unless hospitals release patients from the obligation to pay for the care.

Cleveland's hospitals are required to provide free care. The first source of this obligation is Ohio's statutory Hospital Care Assurance Program, or "HCAP." HCAP requires all hospitals to provide medically necessary hospital-level services free to individuals whose incomes are at or below the federal poverty level. Hospitals receive partial reimbursement from special Medicaid funds for the HCAP care they provide. The HCAP rules also require hospitals to inform people that free care is available. All Cleveland general hospitals participate in HCAP.

The second source of the free care obligation lies in the hospitals' non-profit status. Cleveland's hospitals are exempt from local, state and federal taxation – a privilege that is worth millions of dollars. They also receive substantial charitable contributions and volunteer services. In addition, their non-profit status entitles them to tax-exempt bond financing, a benefit that provides them with capital at interest rates that are lower than they could get in the commercial lending markets. In return for these advantages, the hospitals are expected to use their assets to provide the community with services and benefits, including free care.

Finally, the free care obligation is related to the nature of health care. Health care is an essential service that is critical to the well-being of individuals and communities. Institutional providers of those services, regardless of whether they are for-profit or non-profit, have a social responsibility to provide some measure of free care.

Since 2000, UHCAN Ohio and its members have been monitoring the Cleveland health care safety net. Initial research, which included interviews and meetings with community members, advocates, and health care providers, led to an inquiry about lack of access to free care, primary care, and prescription medications.

The research concluded with a survey by UHCAN members of eleven local non-profit acute care hospitals. The survey, which is the focal point of this report, was conducted in the spring of 2003. It included the following hospitals: Cleveland Clinic Foundation, Euclid Hospital, Fairview Hospitals, Huron Hospital, Lakewood Hospital, Lutheran Hospital, MetroHealth Medical Center, St. Michael Hospital, St. Vincent Charity Hospital, South Pointe Hospital and University Hospital. The purpose of the survey was to determine how easy it is for individuals to get information about free care and whether hospitals had clear policies and procedures on free care. The survey consisted of a series of calls to various departments in each hospital, and at least one site visit. In addition, calls were made in Spanish to five hospitals identified as mostly frequently used by Spanish-speaking patients.

**The purpose of the project was *not* to assess whether hospitals actually provide free care, but rather to assess whether hospitals have an active commitment to people in communities who need care but can't afford it, as reflected by clear, easy-to-use free care policies and procedures and aggressive outreach.**

## Survey Findings

- **Information about the availability of HCAP and other hospital free care programs is difficult to obtain.** Front line hospital staff generally did not appear to be trained to answer free care inquiries or to transfer callers appropriately. Requests frequently resulted in callers either being told there was no free care or that the hospital staff person did not know. Most hospitals did not appear to have written policies on financial assistance for patients whose incomes were too high to qualify for HCAP.
- **Written information about free care programs and hospital policies is not readily available or prominently displayed.** Callers were generally told that there was no written information or that the staff did not know if written information was available. In only one out of eleven hospitals did site visitors find a handout about free care in patient or public waiting areas. No other hospitals produced written material about free care upon request, except for the HCAP application.
- **Spanish-speaking and other limited English speaking people are unable to obtain any information about free care, including HCAP.** None of the five hospitals called was able to provide accurate information, even on HCAP, to callers speaking Spanish, the most common spoken language in Cleveland after English. Callers either were not connected with Spanish speakers or were told in Spanish that free care was unavailable. Except for some Spanish HCAP signs, site visitors found no signs or written materials in languages other than English.
- **Although all of the hospitals have at least some of the required signs describing HCAP, the signs are difficult to find.** They were located only in a few public areas in many hospitals. There were no signs that described the hospitals' own free care policies in addition to HCAP or otherwise offered assistance with hospital bills.
- **Hospitals generally discourage people from applying for free care in advance of receiving services.** At hospitals where callers eventually were able to get information about free care, hospital staff usually said that patients had to wait until after receiving treatment to apply for free care.
- **The only financial assistance forms most hospitals appear to have are those for the HCAP program.** The only hospital with an application other than HCAP requested excessively detailed and intrusive financial information and asked applicants to sign a promissory note.

Taken together, the results demonstrate that Cleveland's hospitals are not doing enough to inform patients and the broader public that free care and financial assistance are available to those in need and to enroll people in those programs. Thus, people may be avoiding needed care because they don't know—and can't easily find out— about free care. Patients may be incurring hospital debt and refusing to seek further needed care, because they are unaware of the availability of free care. The UHCAN Ohio monitors all had a basic level of knowledge about free care, and

they were actively seeking out information. Given the difficulties they faced, individuals with no knowledge about free care may be discouraged early in the process if, in fact, they even think to inquire whether free care exists.

While the present survey focused on one aspect of the free care issue – the availability of information about hospital free care – our broader inquiry also identified other problems with the current system. Those include:

- the apparent absence of free care policies beyond HCAP at most hospitals;
- the lack of trained interpreters and other language services at area institutions;
- the dearth of uniform, meaningful data with which to inform policymakers about the fragility of the safety net; and
- the lack of access to primary care and prescription medications for uninsured and under-insured people, a situation that inevitably leads to preventable hospital visits and admissions.

## Recommendations

**UHCAN Ohio's recommendations reflect the need, not only to strengthen the existing safety net to meet the health care needs of the uninsured, but also to work toward larger systems change that would reduce or eliminate the need for hospital free care. Hospitals are only part of the health care system. Hospital free care is not a substitute for a system of care for everyone. Hospitals, public officials, other safety-net providers and the public must join together in working to build a health care system for the uninsured and under-insured. Affected communities must be involved as full partners in this process.**

UHCAN Ohio recommends:

***First***, hospitals should reach out and actively seek to qualify individuals for Medicaid, HCAP, and their own free care programs. Recommended outreach efforts include: aggressively publicizing the programs, informing uninsured patients about free care options, simplifying and assisting individuals in the application process, and pre-qualifying individuals before they receive services.

***Second***, hospitals should develop specific policies and procedures for people with too much income to qualify for HCAP, to ensure that patients who are unable to pay all or part of their bills receive the opportunity to apply for financial assistance before collection efforts are begun.

***Third***, hospitals should collaborate with each other and the community to ensure that community members have access to hospital free care, by creating a standard, countywide HCAP application and financial assistance application that are widely available and accepted by all hospitals; and by creating a standard, countywide free

care/partial free care policy for uninsured and underinsured patients at or below 400% of the federal poverty level.

**Fourth**, hospitals must provide language services for Limited English Proficiency (LEP) patients to ensure meaningful access to all services and benefits offered to other patients, including health care and financial assistance.

**Fifth**, hospitals should collaborate with each other and with community members and public officials to improve access to primary care and prescription medications for the uninsured. Hospitals should work to support and expand capacity of community health centers and free clinics, as well as operate outpatient clinics that provide free or sliding fee scale care. We believe the community **and** the hospitals will both benefit from ongoing collaboration.

**Sixth**, data on HCAP and the hospitals' own free care programs should be collected and published in a standard format. Data should exclude hospital bad debt, and should reflect patient income. Data collection oversight, data analysis and data publication should be the responsibility of the Ohio Department of Job and Family Services (ODJFS) which administers the HCAP program. Policymakers and the public need more specific data on hospital free care, by patient income, in order to assess the need for policy change, including expanded coverage for the uninsured. And,

**Seventh**, hospitals should establish a close working relationship with representatives of the community to better address community health needs and to join together in seeking county and statewide policy changes that expand access to care to uninsured and underinsured residents.

## A Call to Action

What do we want? We want this report to accomplish the following:

- To engage hospitals in improving hospital compliance with existing free care requirements and undertaking effective outreach to patients needing financial assistance.
- To encourage hospitals to develop policies offering assistance for uninsured and underinsured persons with incomes up to 400% of federal poverty level.
- To reinforce - for Cleveland's leadership and community - the critical nature of free care and the need to ensure that it is readily accessible.
- To challenge hospitals and public officials to involve the community in working to enhance and improve the local system of care for the uninsured with the goal of ensuring their access to the full continuum of services, including primary and preventative care, prescriptions, specialty and hospital care; and

- To challenge local leadership and the community to work for statewide health care access expansions that will reduce or even eliminate the need for a patchwork health care “safety net.”

## INTRODUCTION

UHCAN Ohio’s Free Care work emerged out of its community benefits organizing project, begun in 1998. Community benefits work seeks to improve access to health care by empowering people in medically underserved communities to collaborate with local hospitals on addressing local health needs. In Cleveland and Columbus, UHCAN Ohio began by conducting key informant interviews and convening meetings of people living and working in medically underserved communities. Input was obtained from a broad spectrum of individuals, including people who worked in social service agencies, homeless shelters, food pantries, community health centers, and major hospitals. Among them were social workers, health care providers, agency administrators, outreach workers, and individuals who themselves were uninsured. The purpose of the interviews and meetings was to identify unmet health needs and begin to involve community members in working with local institutions to address those needs.

As UHCAN Ohio’s work groups and task forces in Columbus and Cleveland explored unmet health needs, community members consistently identified two pressing issues that affected the work of every taskforce and workgroup. These issues were:

- Lack of access to free care or sliding fee scales to pay for primary, specialty, and hospital care, and
- Inability of people with Limited English Proficiency (LEP) to obtain interpreters or information about free care and other health care resources.

In Columbus, the first issue led to development of educational materials on accessing free care and the formation of the Free Care Project, which won significant policy and practice improvements from local hospitals. The second issue led to formation of the Columbus Language Task Force, which collaborated with hospitals to develop interpreter programs and trained medical interpreters.

In Cleveland, UHCAN Ohio addressed the barriers facing LEP people by organizing the Immigrant Health Access Coalition, which produced and distributed handbooks in four languages detailing the rights of LEP people to obtain interpreters, free care and other resources. This group continues to improve access for LEP people by uniting community-based agencies and advocates to work with hospitals on improving access to trained medical interpreters.

UHCAN Ohio’s work to improve access to free and reduced-fee care began by convening a group which decided to call itself the Cleveland Free Care Committee (“Committee”). Its membership was drawn from people living and working in medically under-served neighborhoods. Through discussions with community groups and social services agencies, UHCAN Ohio and the

*“The person who answered the phone said that the hospital did not have free care at all. She said that my uninsured friend needs to go to Metro Health.”*

Committee found that many community members, including people who worked in social service agencies, were totally unaware of free care programs that are available at all Cleveland hospitals. As a result, the Committee decided to undertake a more formal assessment of the availability of information about free care and, by extension, the level of hospital commitment to the health and well-being of the communities they serve.

What is Free Care?

**Free care—or “charity care”, as it is sometimes called—is medical treatment provided by a hospital or other provider for which it does not expect to be paid.**

If a person is eligible and approved for free care by the hospital, the hospital will not send bills to the patient or refer the account to a collection agency. “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. The distinction is important. Bad debt 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 individual as it is from a lower-income person who can’t afford to pay for care.

For people who are uninsured or have only limited income, free care (or reduced-fee 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 receive employee health benefits. The availability of free care is particularly important in cities like Cleveland which have significant numbers of uninsured residents who are not eligible for Medicaid, a shortage of primary care providers offering free or reduced-fee care in medically needy neighborhoods, and only limited public hospital capacity.

*“People at the hospital I called knew there was a policy, but they couldn’t find out what it is. No one wanted to talk about the policy.”*

The actual or perceived unavailability of free care can have a catastrophic impact on individuals and families. In some cases, low-income people avoid seeking essential—even life-saving—care if they think they will be billed for it.<sup>1</sup> People without insurance often seek care at a hospital emergency room. Emergency rooms provide emergency care, but they are not set up to provide follow-up or on-going care that might be required. Also, emergency rooms are the most expensive source of non-emergency care – a cost which falls entirely on the uninsured in the absence of free or reduced fee care. If an individual receives care for which he or she can’t pay, the hospital may start collection proceedings. Ultimately, the patient’s credit rating can

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<sup>1</sup> According to the 1998 Ohio Family Health Survey conducted by the Ohio Department of Health, two out of five uninsured Ohioans either delayed receiving or avoided seeking health care because of their uninsured status. Page: 10

[0]The uninsured are two to three times less likely to seek medical care when they experience serious symptoms than people who have insurance, according to a study published in the Archives of Internal Medicine, 5/7/00.

be ruined, wages can be garnished, bank accounts seized, and mortgages foreclosed on. Almost half of all personal bankruptcies are attributable in part to medical debt.<sup>2</sup>

## The Free Care Obligation

The obligation of a hospital to provide free care arises from several different, but equally important, sources. One source of the free care obligation, depending on where the hospital is located, may be a statute, regulation, or ordinance. In Ohio, a state law<sup>3</sup> created the Hospital Care Assurance Program (HCAP). HCAP is the mechanism by which the State of Ohio provides supplemental Medicaid funds – called disproportionate share hospital (DSH) funding -- to general acute care hospitals that provide indigent care.<sup>4</sup> The HCAP law requires any Ohio acute care hospital that receives DSH funds to provide free “basic, medically necessary hospital-level services,”<sup>5</sup> both inpatient and outpatient, to people with incomes at or below the federal poverty level.<sup>6</sup> It’s important to note that HCAP does not cover all hospital-related charges. Physician fees and other types of services that are provided by private entities (such as lab services and durable medical equipment) are not reimbursable through HCAP, potentially leaving an HCAP-eligible patient with large bills.

All general hospitals in Cleveland participate in HCAP. Those hospitals include: The Cleveland Clinic Foundation, Euclid, Huron, Lakewood, Lutheran, MetroHealth, St. Michaels, St. Vincent, South Pointe, and University Hospital.

The HCAP rules<sup>7</sup> promulgated by the Ohio Department of Job and Family Services require Ohio hospitals to take a number of steps to ensure that people know free care is available. Those rules include:

- A requirement that the hospital post notices in appropriate areas, including the admission areas, business office and emergency room
- A requirement that the posted notice state the right of people at or below the federal poverty level to receive care without charge.
- A requirement that the hospital post prominent signs, in English and other languages common to the area served.
- A requirement that the notices be in clear and simple terms.

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<sup>2</sup>Jacoby, M, Sullivan, T., Warren, E., “Rethinking the Debates over Health Care Financing: Evidence From the Bankruptcy Courts,” 76 N.Y.U. Law Review, (May 2001).

<sup>3</sup> Ohio Revised Code section 5112.17.

<sup>4</sup> “Disproportionate share hospital” funding is supplemental Medicaid funding provided to states that they are supposed to apportion in some manner to hospitals which serve a disproportionate number of low-income patients with special needs.

<sup>5</sup> “Basic, medically necessary hospital level services” are defined as all inpatient and outpatient services covered under the Ohio Medicaid program with the exception of transplantation services and services associated with transplantation. The services must be ordered by an Ohio licensed physician and delivered at a hospital where the physician has clinical privileges. Ohio Administrative Code 5101:3-2-0717(A)(1).

<sup>6</sup> The federal poverty level, which changes annually, was \$14,150 for a family of 3, in 2000 (see chart, appendix A).

<sup>7</sup> Ohio Administrative Code 5101:3-2-0717.

- A requirement that posted notices be clearly readable at 20 feet.
- A requirement that the hospital make reasonable efforts to let patients know about the contents of the notice if a person may not be able to read it.

The rules also specify eligibility criteria for free care. HCAP is available to:

- Individuals who are Ohio residents regardless of immigration status;
- Individuals who are not recipients of the Medicaid program; and
- Individuals whose income is at or below 100% of the federal poverty level or who are on Disability Assistance.<sup>8</sup>

Since all of Cleveland's acute care general hospitals participate in HCAP, they are all subject to these rules.

But, the free care obligation is not discharged solely by a hospital's participation in HCAP. Much more is expected of non-profit hospitals in exchange for the multiple benefits – tangible and intangible – that they reap by virtue of their tax-exempt status. All Cleveland-area acute care hospitals are non-profit institutions. As such, they do not pay federal, state or local income taxes. They don't pay state or local sales and property taxes. Their donors get a charitable deduction from their taxes, and community members often are eager to supply services on a volunteer basis. An especially valuable benefit is access to tax-exempt bond financing. Most hospitals feel pressure to build new facilities and add new services or expand existing ones in order to remain competitive in the current environment. Tax-exempt financing offers much more favorable terms than non-profit hospitals could obtain from commercial lending institutions. This benefit alone has substantial value.

In return for the privileges associated with their tax-exempt status, these hospitals are expected to use their assets to provide services and benefits to community members. Historically, the community benefits and services provided by non-profit hospitals have included the provision of free care to individuals who do not have the means to pay some or all of their hospital expenses.

Indeed, this obligation is explicit when Cuyahoga County Commissioners issue tax-exempt revenue bonds on a hospital's behalf.<sup>9</sup> To be eligible for issuance of these health care facility bonds, a facility must demonstrate that it serves a public purpose. The lease agreement it's required to sign with the County incorporates a community benefits statement, which spells out obligations, penalties and remedies. One of the obligations is that the hospital must have a written policy governing access to free and reduced-fee care.<sup>10</sup>

Finally, the free care obligation grows out of the principle that all institutions providing essential services should acknowledge a minimum corporate social

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<sup>8</sup> In 2003, 100% of poverty translates into an annual income of \$8,980 for an individual and \$18,400 for a family of four.

<sup>9</sup> It should be noted that the County bears no responsibility for repaying the debt on these bonds.

<sup>10</sup> The agreements also contain penalties and remedies.

responsibility. Health care is an essential service that is critical to the well being of individuals and communities. When it is not easily accessible, the results can be catastrophic. Because of health care's essential nature, all hospitals, regardless of tax status, have a minimum corporate social obligation to provide some amount of these essential services.<sup>11</sup> This concept is increasingly important in today's health care marketplace. All hospitals, both non-profit and for-profit, face fiscal constraints in a market dominated by managed care. Cost containment demands can cause institutions to consider eliminating critical, but "unprofitable" community services, including free care. Competitive pressures can put those institutions that maintain a commitment to a charitable mission at a disadvantage relative to institutions that either do not have such a mission or have "forgotten" it. In addition, studies show that access to care for the uninsured is diminished in areas like Cuyahoga County that have moved large numbers of Medicaid recipients into managed care.<sup>12</sup>

These realities are spurring public policy makers in some states to implement free care requirements for non-profit and for-profit institutions alike.<sup>13</sup>

## Why Hospital Free Care is Important to Cleveland and Cuyahoga County Residents

### High Numbers of Uninsured People

In 1998, a survey of Cuyahoga County found an estimated 157,000 uninsured residents under 65, including 115,000 non-elderly adults (13.7% of the county's adults) and 42,000 children (12.5% of children).<sup>14</sup> This survey found that the majority of the County's uninsured are working and have significantly lower incomes than those who are insured.<sup>15</sup>

In 2001, the Federation for Community Planning re-surveyed Cuyahoga County and found significantly reduced figures: 22,000 uninsured children, 74,000 adults ages 18-64, for a total of 94,000 uninsured people. This reduction is likely due to several factors, including the 2000 expansion of Medicaid eligibility for children and parents and an aggressive outreach and enrollment effort by the county government; a robust job market at the time; and possible sampling errors in the survey. Experts

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<sup>11</sup> The notion of a corporate social obligation is not unprecedented. Banks are statutorily required to make basic checking services available to all communities and to reinvest assets into the communities they serve. Utility companies are required to service all geographic areas, including "unprofitable" rural regions. Health insurance companies, both for profit and non-profit, are generally expected to offer coverage to all businesses regardless of individual health status, to limit the use of pre-existing condition exclusions, and to assure continuity of coverage for people in transition.

<sup>12</sup> Seifert, RW. "Using Risk Factors to Assess Health Care Access in a Community", from The Access Project, November 2000.

<sup>13</sup> Rhode Island General Law §23-17-41 establishes a standard for provision of free care that applies to all hospitals. Massachusetts General Law Chapter 118G which governs payment of hospital uncompensated care and eligibility for free care applies to all acute care hospitals in the state. Chapter 70.170 of the Revised Code of Washington requires all hospitals to provide free care to certain income-eligible individuals.

<sup>14</sup> 1998 Ohio Family Health Survey, The Ohio Department of Health's Health Care Data Center, as reported in Malakar, Lucy and George Weiner, PhD, "The Ohio Family Health Survey: The Uninsured in Cuyahoga County," *Planning & Action*, publication of Federation for Community Planning, Fall 1999, at 10.

<sup>15</sup> Malakar and Weiner, *supra*, at 11.

anticipate that uninsured numbers will be much higher in 2004, when the survey is repeated, due a decline in employer-funded coverage caused by layoffs, a weak economy, and rising health care costs.

Recent coverage expansions have extended Medicaid eligibility to children in families with incomes of up to 200% of poverty. Parents of dependent children, however, are only eligible if their incomes do not exceed only 100% of poverty<sup>16</sup>, and pregnant women are eligible with incomes up to 150% of poverty. Other adults are only eligible for Medicaid if they are totally disabled and have very low incomes.

A survey of Cleveland consumers in the year 2000 found that 5.2% of Cleveland residents did not get needed medical care during the prior 12 months and 9.2% of those surveyed delayed getting needed medical care during the same period.<sup>17</sup>

### **Higher Rates of Uninsured among Racial and Ethnic Minorities**

The 1998 Ohio Family Health Survey found that most of Cuyahoga County's uninsured live in the east urban areas of Cleveland and East Cleveland. Almost 25% of adults and over 20% of children on the east side had no health coverage. Moreover, non-white adults were twice as likely as their white neighbors to be uninsured,<sup>18</sup> largely because of differences in age, income, educational attainment, and employment status. This reflects national trends, where non-white Americans were at least twice as likely to be uninsured as whites.<sup>19</sup>

High rates of uninsurance among East Side residents undoubtedly contributed to the closing of two east urban hospitals in the past 3 years, Mt. Sinai and St. Luke's.<sup>20</sup> Furthermore, St. Michael's Hospital is scheduled to close its doors in December 2003.

Cleveland's rising population of immigrants, refugees, and other limited English proficiency residents are under-counted in estimates of the uninsured. The unavailability of health insurance in many low wage jobs, exploitation of immigrant workers by some employers, and changes in the federal Balanced Budget Act of 1997 that eliminated Medicaid eligibility for large numbers of legal immigrants have left many with no health coverage, except in certain emergency situations.<sup>21</sup> Nearly two-thirds of working-age Hispanics with low incomes were uninsured for all or part of

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<sup>16</sup> In 2003, 100% of poverty translates into an annual income of \$15,260 for a family of three; 200% of poverty translates into an annual income of \$30,520 for a family of three.

<sup>17</sup>Center for Studying Health System Change, HSC Community Tracking Study Household and Physician Surveys, 2000-01, cited in HSC Community Report: Cleveland Ohio, Fourth Visit, Winter 2002.

<sup>18</sup> Malakar and Weiner, *supra*, at 10.

<sup>19</sup> Key Facts: Race, Ethnicity, and Medical Care. The Henry J. Kaiser Family Foundation, October 1999.

<sup>20</sup> Two other hospitals – St. Michaels and Richmond Heights – nearly closed in 2000, but remained open following community protests. Factors other than patient uninsurance rates put these hospitals in jeopardy.

<sup>21</sup> Alien Emergency Medical Assistance (AEMA) provides Medicaid coverage for medical emergencies, including normal labor and delivery, for non-citizens who are otherwise eligible for Medicaid.

the year 2000, according to a recent Commonwealth Fund report.<sup>22</sup>

### Unmet Needs for Full Range of Health Care Services

The announced closing of St. Michael's has heightened community concerns about lack of access to a wide range of health care services, not only hospital care, as well as the lack of community involvement in decision-making about health care access issues.

Despite the current level of hospital effort and availability of primary care providers seeing patients free or on a sliding fee scale, the need for free or reduced-fee services far outstrips the supply. Cuyahoga County's health and human services levy helps to pay for some uninsured care,<sup>23</sup> but does not come close to meeting the need.

The Free Clinic of Cleveland reported a 35% rise in primary care visits, in the past year, from people who either cannot afford provider visits on MetroHealth's sliding fee scale or who cannot afford to fill prescriptions. Other recent studies of emergency room use and consumer issues around primary care confirm that access to affordable primary care, especially for uninsured and under-insured residents, is wholly inadequate to meet the need. In short, **there is a growing crisis in lack of access to affordable primary care and prescription medications, for uninsured and under-insured people in the Cleveland area.**

### Free Care and the Connection to Racial and Ethnic Disparities in Access to Health Care

Enormous disparities in health status along racial and ethnic lines continue to plague the United States, reflecting a general failure to eliminate institutionalized racial and ethnic discrimination. Racial and ethnic disparities in health care can be traced, in part, to barriers to health care access, such as higher rates of uninsurance among racial and ethnic minorities and fewer providers in under-served communities. As noted above, minority Americans are more likely to be uninsured than white Americans. In addition, minorities are disproportionately represented in the lower income brackets. Uninsured minorities are, therefore, more likely to be dependent on free care policies at area hospitals. Thus, hospital failure to develop and publicize free care and financial assistance policies contributes to the health disparities that disproportionately affect these communities.

Disparities also result from "structural exclusion" -- a combination of policies (or lack of policies) and absence of cultural adaptation by health care providers to the communities they serve. When institutions lack clear, objective eligibility guidelines and open policies and practices that encourage uninsured people to apply, the impact is to shut out a disproportionate share of racial and ethnic minorities from financial assistance. And, when hospitals provide financial assistance on a "case by case" basis, with no clear written policy, the results may be tainted by the racial and

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<sup>22</sup> Commonwealth Fund, 10/16/03, [www.cmf.org](http://www.cmf.org)

<sup>23</sup>A levy is a county tax applied to a specific purpose.

ethnic bias of individual decision-makers. In other words, the lack of established policies and practices on free care may be contributing to the perpetuation of racial and ethnic disparities in access to health care in our community.

## Free Care for Limited English Speaking People: Bridging the Language Barrier

In recent years, Cleveland has welcomed growing numbers of residents with Limited English proficiency (LEP), including: approximately 40,000 Spanish speakers, 30,000 Arabic speakers, 10,000 Russian speakers, and approximately 5,000 Vietnamese. There is also an emerging Somali community. As stated previously, high rates of uninsurance exist among immigrant and LEP populations.

The ability of LEP residents to communicate with health care providers is critical. “Accurate communication ensures the correct exchange of information, allows patients to provide informed consent for treatment, and avoids breaches of patient-provider confidentiality.”<sup>24</sup> Accurate communications also enables LEP patients to learn about and obtain financial assistance, when they need health care but can’t pay for it.

Failure to provide language services, such as trained interpreters and translated signs and other written materials, prevents LEP patients from having meaningful access to either health care services or financial assistance.

LEP individuals are entitled, under federal law, to receive language assistance at no cost, from hospitals and other health providers receiving federal funding.<sup>25</sup> In 2000, the federal government issued guidelines for providers to help them understand their obligations under Title VI of the Civil Rights Act of 1964. These guidelines recommend that providers ensure effective communication with LEP patients by: assessing the language needs of those eligible to be served, as well as of individual patients; development of a comprehensive policy on language services; staff training on provider policies; and ongoing monitoring of language assistance programs.<sup>26</sup>

Hospitals and other providers benefit from ensuring accurate communication with LEP patients, by: ensuring that patients and physicians receive correct information about such vital issues as symptoms, diagnosis, and treatment instructions; and enabling patients to give informed consent for treatment. By taking steps to provide language assistance, providers are also able to connect uninsured LEP patients with payer sources or benefit programs, including Medicaid, Alien Emergency Medical Assistance (a Medicaid program), HCAP and hospital financial assistance. Conversely, when hospitals fail to provide language assistance for uninsured LEP patients, they lose reimbursement for services provided.

## Cleveland Hospitals’ Intense Competition: Good or Bad for the Uninsured?

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<sup>24</sup> National Health Law Program and The Access Project, “Language Services Action Kit, 2003, at 33.

<sup>25</sup> Title VI of the Civil Rights Act of 1964, 42 U.S.C. s2000d, 2000d-4a.

<sup>26</sup> Office of Civil Rights, Policy Guidance on the Title VI Prohibition Against National Origin Discrimination As it Affects persons with Limited English Proficiency, 65 Fed. Reg. 52762 (8/30/2000), available at [www.hhs.gov/ocr/lep/ocrlepguidance.htm](http://www.hhs.gov/ocr/lep/ocrlepguidance.htm).

Following mergers and hospital closures in the 1990's, most Cleveland-area hospitals belong to one of the two major health care systems – the Cleveland Clinic Health System (CCHS) and University Hospitals Health System (UHHS). MetroHealth, the third player, is a public hospital that has struggled to meet increasing demands for free or discounted care, while facing reductions in Medicaid reimbursements and the county subsidy. The two private systems have been extremely competitive with each other, as evidenced by aggressive marketing, expansions, and acquisitions. Competition has, on occasion, led one system's hospitals to deny admitting privileges to physicians from the other system. Both systems have reached into the Cleveland suburbs with outpatient services. Both systems suffered large stock market losses, but, unlike hospitals in many communities, the two systems have been able to use their market power to obtain better terms from health plans to offset losses.<sup>27</sup>

Does the intense competition between the two private hospital systems increase or limit the systems' willingness to provide free or reduced fee care and other community benefits to address unmet health needs? On the one hand, the two systems are reportedly in stable financial condition, giving them the capacity to increase their spending on community benefits. On the other hand, the systems may be spending heavily on marketing, expansion, and other operational expenses, limiting the resources allocated to community benefits. More recently, the intense competition has started to erode, with moves toward greater cooperation among the systems.

## How Free Care Can Help Cuyahoga County's Hospitals

Hospitals claim that resources for free care have decreased in recent years, due to reduced reimbursement levels from managed care payers<sup>28</sup>, Medicare and Medicaid, and federal Disproportionate Share (DSH) funds. Hospitals' spending priorities and stock market losses<sup>29</sup> may have also impacted community benefit expenditures. At the same time, the demand for free care has increased sharply. Hospitals in Cuyahoga County report that they provided \$113.7 million in uncompensated care in 2001. This figure includes \$47.6 million for individuals falling below 100% of the federal poverty level who qualified for HCAP. Another \$59.5 million represents any other free care the hospitals may have provided outside of the HCAP program as well as all other unpaid hospital bills, whether attributable to self-pay patients or unpaid claims submitted to private third-party payers.

Despite the challenges, Cleveland's hospitals have much to gain by actively seeking

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<sup>27</sup> Center for Studying Health Systems Change, "Community Report, Fourth Visit, Cleveland Ohio, Winter 2003," at 2.

<sup>28</sup> Managed care companies, with their ability to direct patient volume to specific hospitals, have been able to negotiate hospital reimbursement rates that are, in some cases, lower than the hospital's costs. This means that hospitals have less revenue to apply to free care and other community benefits.

<sup>29</sup> "The Cleveland Clinic Foundation, in particular, sustained heavy losses from an unusually aggressive investment strategy." Center for Studying Health Systems Change, "Community Report, Fourth Visit, Cleveland Ohio, Winter 2003," at 2.

out individuals who qualify for free care. First, as described earlier, hospitals can receive some reimbursement for free care through the HCAP program. However, they only receive these funds if eligible patients actually apply for HCAP assistance. Thus, if the patient either never applies or applies well after services are received, the hospital cannot include that patient in its HCAP count. Thus, by not reaching out actively to qualify patients for HCAP, an individual hospital receives a smaller distribution from the HCAP pool.<sup>30</sup>

Second, by failing to publicize the availability of free care or to encourage patients to apply, hospitals are losing opportunities to enroll eligible patients in Medicaid and other publicly funded programs.<sup>31</sup> One example of a valuable but under-utilized program is Alien Emergency Medical Assistance (AEMA), which provides Medicaid payments for immigrants who receive emergency treatment or labor and delivery services. If hospitals would reach out to patients -- especially those who are limited English-speaking -- and offer financial help in a more user-friendly way, hospitals would receive more payment for services provided to uninsured patients. In the first year after one Columbus hospital hired a coordinator of interpretation services who instituted policies and procedures, the hospital reported bringing in hundreds of thousands of dollars by signing up undocumented labor and delivery patients for AEMA.

Third, hospitals incur large administrative expenses in debt collection efforts against “self-pay” (i.e. uninsured) patients with little or no ability to pay. By developing better financial assistance policies and procedures, hospitals could reduce debt collection expenses for self-pay patients with no or limited ability to pay.

Fourth, several major national media stories have raised public concern about hospital charges, charity care policies, and debt collection practices. The American Hospital Association (AHA) sent hospitals a “Member Advisory” encouraging them to “perform an ‘audit’ of [their] policies and procedures around these hot issues...”<sup>32</sup> The advisory recommends that hospitals review, and if necessary, *revise* current policies and practices for identifying and assisting patients who may be eligible for free care. It also advises them to review collection practices, particularly with regard to low-income, uninsured individuals.<sup>33</sup> Having fair, consistent, and well publicized policies will help hospitals respond to public questions about hospital practices.

## THE SURVEY: PURPOSE AND METHODOLOGY

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<sup>30</sup> The HCAP pool, from which hospitals receive reimbursements, contains a fixed amount of money each year, so that an individual hospital which reports more HCAP spending receives more in relation to other hospitals from a fixed pot of money; if all hospitals report more, the distribution does not increase.

<sup>31</sup> It should be noted that hospitals have a permanent obligation under the federal Hill-Burton Act (42 U.S.C. 300m et seq.) to screen individuals for eligibility for government programs. Hospitals should ensure staff compliance with this obligation and, at the same time, use it as an opportunity to screen for free care eligibility.

<sup>32</sup> AHA, “Member Advisory, ALERT: Four Related Issues Drawing Medica and Congressional Attention – Know Your Organization’s Policies,” June 10, 2003.

<sup>33</sup> *Ibid*, at 3.

In the summer of 2000, UHCAN Ohio participated in the Community Access Monitoring Survey (CAMS) project which guided organizations in 24 cities in surveying uninsured patients receiving care at local facilities.<sup>34</sup> In October 2000, the results of the Cleveland survey were issued in a report entitled, "Getting Health Care When You Are Uninsured: a Survey of Uninsured Patients at Four Hospitals in Cleveland, Ohio."<sup>35</sup> The majority of respondents reported that hospital staff "never" offered to help look into possible finance assistance for them. Most patients reported high levels of financial stress when trying to pay for care. Sixty to seventy percent said they owed money to the facilities. Of those, 3 out of 10 said that their debt would discourage them from seeking care at the facility in the future.<sup>36</sup>

In the summer of 2002, one of UHCAN Ohio's working groups in Cleveland decided to undertake further research into the safety net. The group had received anecdotal information from community members and agency representatives that uninsured hospital patients were not being told by hospitals about the availability of free care. With participation from community members, the group – which became the Free Care Committee -- conducted a survey of several hospitals. Survey data confirmed that the ability of patients to obtain information about free care varied substantially from hospital to hospital.

*"Is this [free care] for you? We have to speak with the person directly. We can't give you the information. Your friend would have to call into collections. Are you his power of attorney?"*

In January 2003, U.S. Representative Dennis Kucinich released a survey of gross patient revenues versus total charity care at Cleveland area hospitals. That survey showed a wide variation among area hospitals on the percent of patient revenues spent on charity care.<sup>37</sup> For example, the survey reported that in 2000, Cleveland Clinic spent only 1.7 percent of patient revenues on charity care, while MetroHealth Medical Center spent 8.9 percent. This report, along with the multi-state CAMS survey report released the same day, renewed public debate on the topic and reinforced the results of UHCAN Ohio's preliminary survey.

Based on the findings of the various surveys, UHCAN Ohio's Free Care Committee decided to broaden its survey to include eleven non-profit local acute care hospitals. In particular, UHCAN Ohio and its community partners wanted to see:

- Whether it was easy for community members to obtain information about the availability of free care from the hospitals; and
- Whether hospitals had explicit free care policies and procedures.

The survey was also intended to serve as an indicator of the hospitals' compliance with the state's HCAP law and their own policies. The survey methodology was a simple one. A team of consumer volunteers was recruited and trained to make

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<sup>34</sup> CAMS was a project of The Access Project, 30 Winter Street, Boston, MA 02108, (617) 654-9911; [www.accessproject.org](http://www.accessproject.org).

<sup>35</sup> Andrulic, Dennis, et al, "Paying for Health Care When You're Uninsured: How much Support does the Safety Net Offer?" The Access Project, January 2003, at 5.

<sup>36</sup> Ibid, at 6.

<sup>37</sup> Regina McEnery, "Clinic shirks on care of poor, report says," Cleveland Plain Dealer, January 16, 2003, at B-1.

telephone inquiries and site visits to eleven Cleveland area hospitals, seeking information about the availability of free care and the hospital's policy for providing it. In addition, HCAP and financial assistance applications were collected from each of the hospitals and reviewed.

With respect to the telephone inquiry phase, one call was made to each hospital's general information number, billing office, and admitting office during daytime hours. An additional call was made in the evening to each hospital's general information number. Surveyors used the telephone book to obtain those numbers. A total of 34 calls was made.<sup>38</sup> The callers indicated they were calling on behalf of an uninsured friend. They then asked the following questions:

- Do you give free care if someone's income is limited?
- If yes, do you have a written policy? If yes, will you send it to me?
- Is there an application or other paperwork? If yes, will you send it to me?
- What services are covered?
- Whom do you talk to at the hospital to get free care?

In addition, calls were made to five hospitals with individuals asking the same questions in Spanish. The five hospitals called were identified by committee members as those most likely to be used by Spanish-speaking individuals.

With respect to the site visit phase, at least two volunteers went to each hospital to document whether there were signs about the HCAP program or signs that otherwise indicated that free care was available. The volunteers also looked for brochures about Medicaid, HCAP, or the hospital's own charity or free care program. When hospital personnel were readily available, the volunteers also asked for information about free care for low-income uninsured patients.

To ensure uniformity of approach, the callers used a telephone protocol and a site visit protocol. Callers then recorded the results of their telephone conversations and site visits.

### Survey Findings

**While the survey methodology was selected to allow for maximum participation by community members rather than to produce statistically significant conclusions, the findings point to some troubling facts about the availability of free care information from hospitals in Cuyahoga County. They also raise some questions about the level of compliance by area hospitals with the state HCAP law and with commitments made in connection with the issuance of health facilities bonds by the County government.**

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<sup>38</sup> In some cases a separate call was not necessary to each hospital department because the callers were transferred on the initial call.

**1) Information from Cleveland's hospitals about the availability of free care is difficult to obtain.**

In 56% of the calls, the surveyors were told that there was no free care, or the staff person didn't know if there was free care, or the call was never picked up so they were not able to obtain any information.

Only 44% of callers were told that free care was available, including only 20% of evening callers.

On the occasions when the caller was told that free care was available, the overwhelming majority of hospitals only referenced the HCAP program, which only helps people with incomes below the federal poverty level. In three cases, callers were referred to the program at MetroHealth Hospital by staff at other area hospitals.

To the limited extent that staff was knowledgeable about free care, the day staff had more information than the night staff.

Less than half of the calls made resulted in the caller being correctly directed to a department in the hospital where one could find out about free care.

**2) Written information about free care programs and hospital policies regarding free care is not readily available or prominently displayed.**

The majority of callers who were told about the availability of free care were also told that there was no written information about the program or that the staff did not know of written information available. Only 21% were told of a written policy.

Only one of the 11 hospitals had printed material describing free care programs on display or otherwise visible in any patient waiting area. None of the other hospitals had written materials on free care on display or available.

**3) Limited English-speaking callers are unable to obtain any information about free care, including HCAP.**

Not a single Spanish speaker was able to obtain information about free care, by telephone, in Spanish. Two callers were told, in Spanish, that free care was unavailable. Other callers were not connected with Spanish speakers.

Eight of the eleven hospitals had signs in Spanish, but no other language was represented. No other written materials about free care were found in Spanish or any other language.

**4) Although all of the hospitals have at least some of the required HCAP signs, the signs are difficult to find.**

Monitors had to make two visits to several hospitals to even locate the signs. In most cases, the signs were only displayed in a few locations. They were frequently in remote locations or were blocked from view, despite the state rule requiring that HCAP signs be clearly legible from 20 feet.

Only a few of the signs had eye-catching titles, such as “Notice About Free Care.” Eight of the eleven hospitals had signs in Spanish, but no other language was represented. No signs were found about hospital voluntary financial assistance for people with incomes over the HCAP maximum of 100% FPL.

**5) Where callers were told that free care was available, they were frequently told that they could not apply for it until they had actually received services.<sup>39</sup>**

**6) The only financial assistance form most hospitals appear to have is that for the HCAP program.**

Other than the MetroHealth combined application, only one site visitor received an application for financial assistance. Not only was it lengthy and sought detailed personal and financial information, but it also asked the patient to sign a promissory note.

## RECOMMENDATIONS

**The focus of the free care survey was whether information about HCAP and other free care is readily available from Cleveland’s hospitals.** The survey findings demonstrate that in the majority of cases, people did not receive basic, reliable information. Most hospitals have established mechanisms such as applications for the provision of free care through HCAP. With the exception of MetroHealth, they do not, however, appear to have policies for patients with incomes above the HCAP eligibility level. Frontline administrative staff are often unfamiliar with whatever financial assistance policies and procedures that may exist. The surveyors had to be very persistent as their phone calls were transferred from department to department or were caught in voicemail loops. Of particular concern is the fact that the surveyors had basic knowledge about free care and its availability, yet they still faced difficulties. It is easy to imagine that someone with less knowledge would give up much sooner.

For patients with limited English proficiency, the results were even more striking. None of the five hospitals called was able to provide accurate information, even on HCAP, to callers speaking Spanish. Spanish is the most common spoken language in Cleveland after English. Most hospitals were not able to communicate by telephone with Spanish-speaking callers.

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<sup>39</sup> While HCAP rules do not specify when an application for free care should be completed, an official of the Office of Ohio Health Plans, the agency within the ODJFS that administers HCAP, is on record as urging hospitals to have a proactive application process so that individuals can apply at the earliest opportunity. Knowing that one is eligible for free care can alleviate some of the stress associated with having to seek medical care.

Despite the difficulties associated with obtaining information about free care, there is reason to be hopeful that the situation will improve. The annual HCAP audit performed, in 2002, by the Ohio Department of Job and Family Services (ODJFS) which included data reviews of 30 Ohio hospitals, found that virtually none of the hospitals had the required signs in any language other than English. In contrast, UHCAN Ohio's recent survey in Cleveland found Spanish signs in all but 3 hospitals. In addition, almost half of hospital employees were aware of the HCAP program. This suggests that Cleveland area hospitals have made improvements in recent years.

While the present survey focused on one aspect of the free care issue – the availability of information about free care – the broader inquiry identified other problems with the current system. Those include:

- the apparent absence of free care policies beyond HCAP at most hospitals;
- the lack of access to primary care and prescription medications for uninsured and under-insured people, a situation that inevitably leads to preventable hospital visits and admissions;
- the lack of trained interpreters and other language services at area institutions; and,
- the dearth of uniform, meaningful data with which to inform policymakers about the fragility of the safety net.

**Hospital free care is not a panacea for the crisis of the uninsured. UHCAN Ohio's recommendations reflect not only the need to strengthen the existing safety net to meet the health care needs of the uninsured, but also to build collaboration and capacity to effect larger systems change that would reduce or eliminate the need for hospital free care.**

UHCAN Ohio's recommendations are consistent with the recommendations of the American Hospital Association (AHA) to its member hospitals in its June 10, 2003 alert. Those recommendations include:

- Reviewing and, if warranted, revising current policies and practices for identifying and assisting low income patients;
- Making “charity care” policies available to consumers in easy-to-understand language, as well as in languages commonly used by patients in the community;
- Training staff to be able to answer consumers’ “charity care” questions accurately;
- Encouraging patients to ask questions about their bills and discuss with staff any need for financial assistance; and,
- Finding ways for hospitals to adjust bills for uninsured individuals.<sup>40</sup>

**UHCAN Ohio believes all hospitals *must* work with community members and groups and to address flaws, not only in the provision of hospital free**

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<sup>40</sup> AHA Alert, supra, at 3.

**care, but in the health care system as a whole.** Despite the coverage expansion programs of the last several years, serious access problems persist. Because free care is an essential part of the health care safety net, it is critical that the system work. In light of the minimal state and local oversight of free care programs, it is particularly important for the parties – community members, community organizations, and hospitals -- to develop a relationship of mutual trust and respect. Beyond hospital free care, hospitals and the community need to work on addressing the broader gaps in the system.

There are a number of steps that can be taken now by hospitals to ensure that current obligations are being met. UCHAN Ohio's recommendations are as follows:

## Individual Hospitals

### We recommend that individual hospitals:

- 1) Reach out and work actively to qualify individuals for HCAP, Medicaid and their own free care programs. Hospital outreach initiatives could include the following actions:
  - ◆ Post clear, visible and readable notices in English and other languages<sup>41</sup> throughout the hospital about HCAP and the hospitals' own free care program. The signs should, at a minimum, be consistent with HCAP specifications.
  - ◆ Develop clear, understandable brochures that describe HCAP and the hospital's own free care program, and make them available throughout the hospital in multiple languages. These brochures should, at a minimum, be available in hospitals waiting rooms and all patient service desks.
  - ◆ Develop a uniform, consistent process by which individuals can apply for free care programs **before, during, or after** receipt of services. The process should be simple (e.g. a short, easy-to-understand application that provides for self-declaration of financial status), respectful, and generally user-friendly. The process should also encourage individuals to apply for free care at the earliest possible time, preferably before the receipt of services.
  - ◆ Provide each uninsured/self-pay or under-insured patient with free care information and offer assistance in applying, at time of registration and at time of discharge, and otherwise upon request; give information verbally to patients who may not be able to read signs or brochures.
  - ◆ Train hospital staff, including admitting, switchboard, general information, financial, billing, social service and emergency room staff, about the various free programs and where to refer inquiries

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<sup>41</sup> Consistent with the guidance issued by the federal Department of Health and Human Services' Office for Civil Rights.

about free care. This should be done in initial staff orientation and in periodic in-service training. Educate staff to be sensitive to varying levels of literacy.

- ◆ Provide information about free care by telephone 24-hours a day, in multiple languages.
- 2) Develop policies and procedures to ensure that patients who are unable to pay all or part of their bills receive the opportunity to apply for financial assistance before collections efforts are begun.
- ◆ Develop written policies providing complete free care to patients with incomes up to 200% FPL, and partial free care for patients with incomes from 200% to 400% FPL and financial assistance for other individuals for whom payment would cause serious financial hardship.
  - ◆ Prior to any assignment of accounts to the collections process, review each patient's file to confirm that a financial assistance determination was made correctly or that reasonable efforts were made to contact the patient with information about free care.
- 3) Assist HCAP and other free care patients in obtaining prescription medications and other non-covered services, so as to ensure appropriate follow up and continuity of care. Assistance could include:
- ◆ Creating pharmacy assistance programs that would provide uninsured patients with needed medications or pharmaceutical samples, upon discharge, to ensure continuity of any prescription drug regimen.
  - ◆ Developing procedures for forwarding notification of HCAP or other free care program eligibility to providers of services that are not covered by hospital free care to facilitate write-offs or reductions of bills for non-covered services.
  - ◆ Scheduling, whenever possible, follow up appointments for HCAP or other free care patients at hospital clinics covered by HCAP or other hospital free care programs.
- 4) Establish a close working relationship with representatives of the community within which it operates to better address community health issues:
- ◆ Working together, hospitals and community groups should develop a process for regular consultation and feedback, and for joint development of policies, such as free care policies, that meet the community's needs.
  - ◆ Hospitals and community groups should collect and share data related to community health issues such as the provision of free care and patient satisfaction.

- ◆ Hospitals should use community groups—and community groups should make themselves available—for community outreach on hospital programs such as HCAP and free care.

## Hospital Collaboration

### **We recommend that hospitals collaborate with each other to:**

#### **1) Ensure that community members have access to affordable, quality health care by:**

- ◆ Creating a standard, countywide HCAP application, based on the state model, and a standard countywide financial assistance application that are available throughout the community and accepted by all hospitals.
- ◆ Creating a standard, countywide free care policy, including free care for all patients at or below 200% of federal poverty level, partial free care for individuals from 200 to 400% of poverty, and financial assistance to those whose hospital bills would otherwise cause serious financial hardship.
- ◆ Working to expand access to primary care for uninsured and under-insured residents, by developing a cooperative and supportive relationship between hospitals and primary care safety net providers, including federally qualified health centers and free clinics.
- ◆ Working with other stakeholders, including community groups, on seeking broader policy changes to insure more people, including an expansion of Medicaid to more working parents and establishment of a county system of care for the uninsured.

#### **2) Collect more specific data on HCAP and charity care and develop a standard format for reporting HCAP and free care by:**

- ◆ Collecting data on uninsured and under-insured patients, broken down by <100% poverty, between 101-200% poverty, between 201-400% of poverty, Medicaid, and other; and
- ◆ Reporting to the community, on an annual basis, their data on HCAP and charity care, using the hospitals' audited financial statements.

### **SUMMARY**

Most local health care providers – and the hospitals in particular -- maintain that the cost of treating uninsured people is placing an ever-increasing burden on Cleveland's health system. Additional local, state, and federal resources may be essential to ensuring a strong safety net. There are two things that can be done simultaneously right now to strengthen the existing system and make the case for additional resources.

First, hospitals need to work together and with the community to strengthen the continuum of care for the uninsured. For example, they should collaborate with the existing primary care resources, including federally qualified health centers, hospital clinics, and free clinics, with the goal of creating a more cohesive, efficient system of care for the uninsured. A better system of care would reduce inappropriate use of emergency rooms and avoidable hospital admissions for patients with conditions that could be managed more effectively in primary care settings. Improved health status for these vulnerable individuals would reduce the need for hospital free care.

The second thing that hospitals, primary care safety net providers, the public health infrastructure, and the community need to collaborate on is building the case for additional resources. Getting policymakers to address the issue will require the collection, analysis and publication of detailed data that clearly demonstrates the extent to which the system is under pressure. Hospital data should, at a minimum, include the amount of free care provided to patients in ranges relating to the federal poverty level. Data also must distinguish free care granted to uninsured patients from bad debt (uncollected bills). As other communities have recognized, collecting data on “charity care” can serve as compelling evidence of the need for additional resources.<sup>42</sup>

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<sup>42</sup> The City and County of San Francisco Department of Public Health issued Charity Care Regulations, in December 2001, requiring hospitals to report the amount of Charity Care provided, expressly to “enable the City and County of San Francisco to evaluate the need for Charity Care in the community and to plan for the continued fulfillment of the City’s responsibility to provide care to indigents.”