



CLEARING THE FOG

Achieving Reasonable Public Disclosure of
Available Free and Reduced Cost Health Care
in Galveston County, Texas

This report is dedicated to the memory of Matthew Stanford who contributed substantially to this project. In this work and many others in our community, Matt taught so many of us to walk in our own shoes.

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About the Author

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Executive Summary

Beginning in 2006, the Cancer Coalition of Galveston County commissioned videotaped interviews of local cancer patients and the community agency and social service staff attempting to help these patients, in order to illuminate the real stories and concerns that impact them. The interviews revealed tremendous difficulties with access to care often due to a health care system that is opaque and layered with barriers, particularly for uninsured or underinsured patients. A shortened videotape, called a “Calling Card” was created from the longer interviews in order to bring the stories of these difficulties to policymakers. The Calling Card succeeded in presenting a powerful story of the struggles of local cancer patients and their advocates but it did not offer a clear course of action for policymakers.

A Subcommittee for a Legislative and Policy Agenda was formed from members of the Cancer Coalition of Galveston County and a model project was chosen based on a national series of projects developed and supported by Community Catalyst. Community Catalyst is a national nonprofit health care advocacy organization. The projects were called Free Care Monitoring Projects and primarily assessed and enhanced transparency and accountability in local charity care and discount policies at hospitals. The Subcommittee adapted the Community Catalyst model to Galveston County hospitals and clinics and completed surveys between November 2007 and January 2008. The purpose of the project was to: 1) obtain information from local hospitals and clinics about free and reduced cost care, and 2) use the surveys and other information obtained through research to improve access to health care by enhancing public disclosure of policies on free and reduced cost health care.

The surveys were designed to find out whether Galveston County health care organizations provide free care to people in need of such care, whether there are written policies regarding free or reduced cost care, and how easy or hard it is to obtain information about free or reduced cost care.

The following hospitals and clinics were surveyed and/or site visits were made:

- Mainland Medical Center (for-profit)
- University of Texas Medical Branch Hospital (public)
- Christus St. John Hospital (nonprofit)
- Clear Lake Regional Medical Center (for-profit)
- Galveston County Health District Clinics (4Cs Clinics) in Galveston and in Texas City (Federally Qualified Health Care Centers)
- UTMB Clinics (public) in Galveston and on the mainland including:
 - Primary Care Pavilion A (Harborside Drive)
 - Primary Care Pavilion B (Harborside Drive)
 - University Hospital Clinics
 - Stewart Road Clinic
 - Ursuline (39th Street) Clinic

Family Health Care Center in Texas City (6400 Memorial Drive)
Pediatric Clinic in Texas City (6400 Memorial Drive)

Findings include information from all of the hospitals and clinics surveyed. However, recommendations are made only for Galveston County health care organizations.

General Findings:

- During the surveys and site visits of Galveston area for-profit hospitals, one nonprofit hospital, Federally Qualified Health Care Centers, one public hospital and the public hospital clinics, all of the organizations reported that no free care was available.
- No written policies on free or reduced cost care were provided to the monitors for Galveston County hospitals and clinics during the survey period. However, Christus St. John Hospital in Harris County provided a written policy on charity care and the 4Cs Clinics provided a web-link to policies after the surveys were completed.
- All of the Galveston County hospitals and clinics reported that policies were available internally, for possible discounted care, but not available to the public.
- Senate Bill 1731 became effective September 30, 2007. It requires that hospitals and physicians develop, implement, and enforce written policies that address discounting of charges (to uninsured persons or the financially or medically indigent consumer) or a written charity care policy. The law also requires the posting of a clear and conspicuous notice of the availability of the policies in waiting areas and in registration, admission, or business offices. During the survey period, none of the organizations surveyed were in compliance with this law.
- The American Hospital Association (AHA) is the national organization that represents and serves all types of hospitals and health care networks. In 2004, the AHA issued guidelines on hospital billing and collection practices. These guidelines include the following statements: Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance. Hospitals should ensure that all written policies for assisting low-income patients are applied consistently. All of the hospitals surveyed signed a “confirmation of commitment” to the AHA principles and guidelines pledging to adhere to the AHA guidelines and principles.

General Recommendations:

- Galveston County hospitals and hospital clinics should, as required by the Texas Health and Safety Code, post notice in waiting areas, registration areas, and admission or business offices about the availability of written policies on charity care and financial discounts.
- Galveston County clinics that are not hospital-affiliated should, as required by physicians in the Texas Occupations Code, develop, implement, and enforce written policies for the billing of health services that address discounts and charity care for health care services provided to qualifying patients. A clear and conspicuous notice should be posted on the availability of the policies in the waiting area and in any registration, admission, or business office in which patients are reasonably expected to seek service.
- Galveston County hospitals should, as evidence of their commitment to the American Hospital Association's guidelines and principles, apply the charity care and financial discount policy consistently. The hospital should communicate information about the policy in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in the community. The policy should be shared with appropriate community health and human services agencies and other organizations that assist people in need. All staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) should be educated about hospital billing financial assistance and collection policies and practices.
- Galveston County hospitals and clinics should publish their charity care and financial assistance policies annually in the Galveston County Daily News.

Site Specific Findings and Recommendations:

Mainland Medical Center

Findings:

- In twelve phone surveys and site visits to Mainland Medical Center, monitors were told that no free care was available and no written policies on charity care or financial assistance were provided.
- Mainland Medical Center is part of Hospital Corporation of America (HCA).
- HCA has a charity care and financial discount policy available on their website and the CEO has testified to Congress about HCA's charity care policy.

Recommendations:

- Mainland Medical Center should adopt the charity care and financial assistance guidelines that were outlined by Hospital Corporation of America during congressional testimony in 2004. According to the policy, there is free care for any patient who receives non-elective treatment and whose household financial resources and/or income is at 200 percent or below the federal poverty level.

Galveston County Coordinated Community Clinics (4Cs)

Findings:

- In eighteen phone surveys and site visits to 4Cs in Galveston and Texas City, monitors were told that no free care was available and no written policies on charity care or financial assistance were provided. An internet link to a table of discounted care was provided.
- Signs were posted regarding the availability of discounted services, though not on the availability of written policies regarding such services.
- After the surveys were completed, an internet link was provided to the following documents: 1) an application for discounted services, 2) a table of financial discount guidelines based on the federal poverty level (2007 level), 3) a 4Cs patient financial guide that provides details on all copayments required, 4) the 4Cs collection policy that includes details on the use of collection agencies for unpaid bills, 5) a thorough list of medical fees and copayments, and 6) other related documents.
- 4Cs is a Federally Qualified Health Care Center and is required by federal law to see patients regardless of their ability to pay.
- Medical services at 4Cs are discounted 100% for uninsured people whose income is below the federal poverty level. Services are discounted on a sliding fee scale for people with incomes below 200% of the federal poverty level. All uninsured people are responsible for a copayment for services. For example, the copayment is \$12 or \$15 for a medical or dental provider visit.
- Requiring a copayment for uninsured people whose income is below the federal poverty level appears to be a common practice in community health centers in Texas. However, cost sharing, such as copayments, has been shown to reduce necessary care with a greater harmful effect among poor people. The National Association of Community Health Centers has urged the federal government not to require copayments at community health centers for Medicaid patients, most of whom have incomes below the federal poverty level.

- Community health centers are not required by any laws or regulations to charge any fees to people whose income is below the federal poverty level.
- The use of a collection agency by community health centers does not appear to be a common practice. There is some evidence that people whose accounts are referred to a collection agency are much less likely to return to that site for care as well as to delay obtaining health care. Actions by collection agencies can affect overall financial security leading to housing problems and poor credit ratings.

Recommendations:

- 4Cs should continue to post notices on the availability of discounted services.
- 4Cs should either not impose copayments for health services on people whose income is below the federal poverty level, or allow waiving of these copayments without incurring a medical debt.
- 4Cs should not use aggressive billing practices, such as turning over accounts to a collection agency.

University of Texas Medical Branch

Findings:

Results of Surveys and Site Visits

- In thirty-eight of thirty-nine phone calls and site visits, monitors were told that no free care was available and no written policies on free or reduced cost care were provided. In one phone call to the hospital main number, the monitor was told that free care is available and the call was immediately transferred to the Demand and Access Management Program (DAMP) office. During one phone call, a community monitor was told that discounted care is available based on federal poverty guidelines, though the policy was not allowed to be shared with the public.
- No signs were posted regarding the availability of written policies on free or reduced cost care at any of the hospital or clinic sites.
- In twenty-six of the thirty-nine phone calls and site visits, monitors spoke to or were referred to personnel in the Demand and Access Management Program (DAMP) office. The DAMP office is a self-described processing center for uninsured patients that facilitates requests for unsponsored nonemergency care. DAMP office personnel often did not know whether UTMB provides any free care or responded that there is no free care at UTMB. Several monitors were told that discounted care is available but that there is no written policy regarding

financial assistance. During several surveys, monitors were told to “go to your county,” even though all of the monitors were Galveston County residents, or monitors were told to go to 4Cs clinic.

- Decisions about who is accepted for possible discounted care, according to a DAMP administrator, are not known by DAMP personnel but seem to be based on the needs of the clinic for training and educational purposes. The DAMP administrator stated that there are no written policies for patients, referring physicians, or internally for the DAMP office personnel.
- At the UTMB clinics, monitors were told that UTMB does not provide free care and that patients who cannot pay or do not have health insurance are referred to the 4Cs clinic and other non-UTMB sites. Some monitors were told that there is an application for health care services online. Hospital personnel reported there is “absolutely no free care” and everyone must be financially screened to determine a copayment.
- No written policies were made available to the monitors regarding eligibility for charity care or financial assistance. No charity care or financial assistance policies were available online. An application for financial assistance was available online.

Research on Hospital Policies on Charity Care and Financial Assistance and UTMB Obligations Regarding Charity Care and Financial Assistance

- In a national survey of hospital executives, over half reported that their hospital posted charity care policies online, two-thirds posted the policy in public places, and over three-fourths provide the policy on admission.
- Charity care is reported annually by UTMB to the Texas Department of State Health Services.
- Charity care and bad debt are components of “uncompensated care,” a term that is recognized as inexact, at best. The concept of uncompensated care is that it is care given where no payment is received. Designating such care as charity has an enormous impact on people as compared to designating such care as bad debt.
- UTMB reports to the Texas Department of State Health Services that there is a charity care policy and that it includes a formal eligibility system.

Research on the UTMB Processing Center for Uninsured and Underinsured Patients

- In two-thirds of the surveys, monitors spoke to personnel in the DAMP office. Information on whether the DAMP office currently exists is conflicting. However, the DAMP office was perceived by most survey responders to be the place to

refer all questions regarding free or reduced cost care and operation of the DAMP office may provide a clue as to future approaches to uninsured people.

- In over ten years of operating DAMP, no written policies for patients, referring physicians, or internally for the DAMP office were created regarding who would be accepted for care.
- The DAMP office has functioned in three tiers: 1) financial screening and copayments, 2) departmental caps on the number of uninsured patients accepted, and 3) referral judgments.

Research on Required Payment Levels at UTMB for Uninsured and Underinsured Patients

- When the DAMP office was created in 1998, patients with the lowest incomes would be responsible for an upfront payment of 25 percent of the standard charge and would be billed for a total of 50 percent of the standard charge.
- In 2003 uninsured people with the lowest income paid \$30 for an outpatient visit and, in 2008, uninsured people with the lowest income paid \$40 for an outpatient visit. The income eligibility level has not been disclosed to the public.
- The lowest income people pay more than people with health insurance coverage through Medicaid and Medicare and people in these low income categories pay about the same as people who have private health insurance.
- The amount of hospital services charged to uninsured people above 250% of the federal poverty level was about twice as much as people with commercial insurance, according to a UTMB financial officer in 2006.
- With the exception of children, health care services are denied for uninsured people unless an upfront payment is made. Requiring upfront payments is not a common practice. According to an Internal Revenue Service survey, 85% of hospitals did not require payment prior to providing inpatient, outpatient, or emergency room services.

Research on Required Reporting of Charity Care by UTMB

- It is not clear that any health care services adhering to DAMP payment procedures and the Deposit Guide for Services at UTMB could be referred to as charity care under one definition of charity care on the Annual Hospital Survey provided to the Texas Department of State Health Services. That definition is:

Health care services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide

health care services free of charge to individuals who meet certain financial criteria.

In 2006, under this definition \$161,265,948 was reported in charity charges and, in 2007, \$152,955,359 was reported in charity charges. The one case where no hospital can refuse to care for uninsured patients regardless of ability to pay is when there is a condition deemed to be a medical emergency. This law does not prohibit hospitals from billing patients for emergency treatment.

- There are few references to charity care by UTMB. One reference to the term “charity care” refers to patients from counties contracting with UTMB. This raises at least two questions about who is included by UTMB in the reporting of charity care. The first question is whether charity patients reported on the Annual Hospital Survey receive *services free of charge* and the second is whether patients funded by county contracts are designated as charity patients. A legislative work group recommended that these funds be reported as sources of payment.

Research on Public Funds for “Un-sponsored Care”

- According to Navigant Consulting, in 2006, funds internally allocated for un-sponsored care paid the hospital at a rate that was 113% of the Medicare rate and paid the physicians at a rate that was 147% of the Medicare rate.
- In 2006, revenue supporting un-sponsored care at UTMB almost entirely covered the cost of un-sponsored care, leaving a deficit of \$40,000.
- The DAMP process can be considered a process of allocation of funds, rather than a process of rationing. In 2006, of the \$118.96 million allocated for un-sponsored care, \$111.41 million was public funding and \$7.55 million was derived from patients’ cash payments.

Research on the Relationship of Charity Care to Bad Debt

- It is not known whether charity care is available or whether any person is told about charity care if it is available. However, at UTMB charity care on required reports has declined proportionate to an increase in bad debt. From 2005 to 2008 the amount of services designated as charity care has declined by 36% and the amount of services designated as bad debt has increased by 44%. Since 1999, charity care has declined by one-half as a percentage of revenue, from 20.6% to 10.7%.
- Medical debt can have devastating consequences for patients and for families.
- DAMP rules are credited with the creation of computer “bad-debt flags.” A staggering 64,000 people were subject to bad-debt flags in 2003. These flags do not allow an appointment to be made, except under certain circumstances. For

accounting purposes, the Healthcare Financial Management Association recommends recording bad debt only when collectibility is reasonably assured.

- DAMP procedures included other bureaucratic barriers such as an off-campus location and “hard-blocks” that prevent follow-up appointments after an emergency department visit.

Research on Referral Judgments and Priority Setting

- Referral judgments are made by financial screeners based on visually scrutinizing patients.
- Referral judgments are also made by area medical directors based on paper forms from health care providers who have determined that specialty services are needed.
- There is no publicly available information on how referral judgments are made or on what basis priorities are set, except that reducing uncompensated care costs and teaching or educational needs have been mentioned. In the first seven months of 2006, 4,423 patients were excluded from health care services while 5,863 were accepted for appointments.
- Priority setting in health care is of deep concern to many Americans and to congressional leaders. The process of deciding who receives care and who is excluded is often considered to be as important as the criteria developed for decision making. Transparency, fairness, and openness to revision are vital to priority setting.
- The basis for decision making in hospitals for the care of uninsured patients should revolve around consistency.

Research on the Effect of UTMB Procedures for the Uninsured and Underinsured on Galveston County Residents

- DAMP procedures in Galveston County have resulted in an inability of residents whose physicians have determined specialty care is needed to obtain those services in over three-fourths of cases.
- Providers of health care services by public hospitals and community health centers are highly interdependent. In Galveston County, implementation of DAMP affected the community health centers’ ability to refer mutual patients for needed specialty services.
- Several terms used to refer to health care for the uninsured and sources of funding for the uninsured can obscure as many details as they describe. For example, if only the term “uncompensated care” is used, charity care could decline to zero

and the total amount could be comprised only of bad debt. Another source of confusion is that “indigent health care” and “unsponsored health care” can both be categories of specific patients and sources of funding. For example, “indigent health care” could refer to funds received through County Indigent Health Care sources or unclaimed lottery funds designated for indigent health care.

- The lack of publicly available policies on charity care and reduced cost care combined with high levels of copayments, billing the uninsured at rates higher or comparable to the commercially insured, bureaucratic barriers, opacity of priorities and criteria for acceptance for specialty care, and nondisclosure of public financing, all contribute to difficulties in access to health care in Galveston County.

Recommendations:

- Health policies developed by UTMB regarding uninsured or underinsured patients should have publicly available written policies. Such policies should be evaluated and revised based on their effects on the health of patients.
- Charges billed to the uninsured or underinsured should be based on written policies and applied consistently. At a minimum, eligibility for designated charity care should apply to all patients with incomes below the federal poverty level. Templates for developing and applying financial assistance procedures are available from a number of organizations, including the Texas Medical Association, the American Hospital Association, the Healthcare Financial Management Association, Community Catalyst, PriceWaterhouse Cooper, and many others.
- UTMB should determine eligibility for charity care as soon as possible when health care services are needed and revise the eligibility based on continued circumstances. UTMB’s charity care policy should address situations in which not all income or other information is available from the patient.
- UTMB should make every effort to identify patients eligible for charity care and distinguish eligible patients from people whose accounts are considered bad debt.
- UTMB should either not impose copayments for health services on people whose income is below the federal poverty level, or allow waiving of these copayments without incurring a medical debt.
- Internal payment levels should be cost based so that available public funds are used to care for the maximum number of patients possible.
- UTMB should report the sources of public funding for services to the uninsured and underinsured and the residual deficit or surplus.

- The allocation of public funds should be made through a transparent, public process that is accountable to the public, particularly the local community.
- UTMB's reporting of charity care on the Annual Hospital Survey should correspond to the definitions explained on the survey.
- Bureaucratic barriers, "hard-blocks," bad debt flags, and denial of services for people without cash payments place excessive burdens on uninsured and underinsured patients, create an adversarial relationship, and have strong negative health consequences. UTMB should discontinue these practices.
- UTMB should reconsider its role in the health of Galveston County residents and the shifting of health care responsibilities to the 4Cs clinics where available providers are one one-hundredth of the providers available at UTMB.
- UTMB should report information on health care for the uninsured and on funding for the uninsured so that transparency is achieved. In the case where terms used have variable and inconsistent meanings, these should be explained to the public.
- UTMB should strive to achieve transparency in health policies and practices and accountability to the public for those policies and practices.

Galveston County Free Care Monitoring Project

Introduction

In 2006, the Cancer Coalition of Galveston County (CCGC) commissioned videotaped interviews with local cancer patients as well as community and social service agency staff attempting to help these patients with services, in order to illuminate the real stories and concerns that impact them. These videotaped interviews revealed that cancer patients often not only have the burden of a devastating diagnosis, but they also face a health care system that is opaque, difficult to access, and creates layers of barriers to care.¹ In particular, for those cancer patients who are uninsured or underinsured, there can be unnecessary suffering, personal financial ruin, and loss of dignity as they traverse their way through a patchwork of health care programs, institutions, and providers.²

The CCGC decided to respond to the stories that cancer patients told by creating a twelve minute video, the "Calling Card," which contains snapshots of those stories and comments by members of the CCGC. Hoping to improve the circumstances faced by local cancer patients, the CCGC set an agenda to bring the stories to policymakers. Mindful that presenting the problems elucidated in the video would not offer any recommendations or solutions that policymakers could act upon, a CCGC Subcommittee for a Legislative/Policy Agenda was formed to recommend potential plans of action.

Rather than reinvent the wheel, the Subcommittee found a national model for community coalitions seeking to improve health care at a local level. Several communities across the nation have been able, through local coalitions, to improve information available to community members on their health care organizations. Therefore, the CCGC Subcommittee suggested adapting a national model to Galveston County. The chosen model came from Community Catalyst, a national non-profit health care advocacy organization.³ Between 1999 and 2003, Community Catalyst supported several community initiatives across the nation that assessed the availability of hospital free or reduced-price care. In many cases, the Free Care Monitoring Projects in each community were able to work with local hospitals and state lawmakers to improve public disclosure of free and reduced cost health care, as well as achieve a wide range of goals that improve access to health care.⁴ The focus of the project would not be specific to cancer patients; it would involve the entire community.

¹ In 2001, the President's Cancer Panel heard similar stories throughout the nation.

² Harold P. Freeman, Chairman, "Voices of a Broken System: Real People, Real Problems," ed. Suzanne H. Reuben (National Institutes of Health, National Cancer Institute, 2001).

³ For information on Community Catalyst, see their website at:
http://www.communitycatalyst.org/about_us?id=0001

⁴ Community Catalyst, "Not There When You Need It: The Search for Free Hospital Care," (Boston, MA: Community Catalyst, 2003).

Community members were recruited and trained to survey local hospitals and clinics to document:

- Whether the hospital or clinic has a written, formal free care policy or financial assistance policy
- How easy or hard it is to find out about the free care or financial assistance policy
- What steps the hospital or clinic takes to inform people about free or reduced cost care
- What the process of obtaining free care is like
(Is it relatively easy or complicated? Is the process respectful?)

The Cancer Coalition suggested surveying both clinics and hospitals in Galveston County. The Coalition also wanted information on two hospitals outside of Galveston County but that many Galveston County residents were perceived to rely upon. Findings from all of the hospitals and clinics surveyed are described in this report. The following hospitals and clinics were surveyed and/or site visits were made:

- ✓ Mainland Medical Center
- ✓ University of Texas Medical Branch Hospital
- ✓ Christus St. John Hospital
- ✓ Clear Lake Regional Medical Center
- ✓ Galveston County Health District Clinics (4Cs Clinics) in Galveston and in Texas City
- ✓ UTMB Clinics in Galveston and on the mainland including:
 - Primary Care Pavilion A (Harborside Drive)
 - Primary Care Pavilion B (Harborside Drive)
 - University Hospital Clinics
 - Stewart Road Clinic
 - Ursuline (39th Street) Clinic
 - Family Health Care Center in Texas City (6400 Memorial Drive)
 - Pediatric Clinic in Texas City (6400 Memorial Drive)

The project included the following steps:

- Phone calls inquiring about the hospital's or clinic's free care or financial assistance policies
- Hospital and clinic site visits to document signs regarding free care or financial assistance and discounted care
- Group discussion about the experiences and the monitoring results
- Review of related research
- Completing written report

The purpose of the project was to: 1) obtain information from local hospitals and clinics about free and reduced cost care, and 2) use the surveys and other information obtained through research to improve access to health care by enhancing public disclosure of policies on free and reduced cost health care. The template for the project, provided by Community Catalyst, was adapted to Galveston County clinics and hospitals.

Community Catalyst now publishes the guide for free care monitoring projects on its website.⁵ The Galveston County project differed from previous projects using Community Catalyst's guide because Galveston County has a public hospital and a for profit hospital and clinics were included, whereas previous projects were primarily directed at nonprofit hospitals.

Phone calls were conducted by a variety of individuals:

- Uninsured callers seeking information about the free care policy or financial assistance policy from the hospital's or clinic's general phone number (Spanish and English)
- Staff of a community-based agency seeking information from the financial department and social service department and other relevant departments

Phone calls were made by uninsured persons seeking free care information:

- Each hospital and clinic was called by the same uninsured monitor at least 2 times.
- Each call was made to the main hospital number at different times of the week (a weekday call and an evening call,).
- An English-speaking and Spanish-speaking caller was assigned to each hospital

Phone calls were made by local community agency based staff:

- Calls were made to the hospital social services department
- Calls were made to the hospital billing and/or financial screening departments and related departments
- Calls were made to clinics

Volunteers representing a faith-based organization made site visits:

- Visited waiting rooms, registration and admitting areas, hospitals' emergency rooms, and billing departments
- Looked for and recorded any posted signs or printed materials about free care, availability of public programs, payment or billing practices
- When staff were not busy – introduced self and asked for information about hospital's or clinic's free care policy

As the project began, the Subcommittee became aware of two relevant sources of information regarding hospital and physician practices concerning charity care and financial assistance. The first source was from the American Hospital Association and the second source was a law enacted in the 80th legislature.

The American Hospital Association (AHA) is the national organization that represents and serves all types of hospitals and health care networks. In 2004, the AHA issued guidelines on hospital billing and collection practices. These guidelines include the following statements: Hospitals should make available to the public information on

⁵ Community Catalyst, *Free Care Monitoring Project: A How-to Guide for Advocates Seeking to Improve Hospital Free Care Programs* (2008 [cited September 1 2009]); available from http://www.communitycatalyst.org/projects/hap/free_care/pages?id=0006.

hospital-based charity care policies and other known programs of financial assistance. Hospitals should ensure that all written policies for assisting low-income patients are applied consistently. (Figure 1) All of the hospitals surveyed signed a “confirmation of commitment” to the AHA principles and guidelines pledging to adhere to the AHA guidelines and principles.⁶

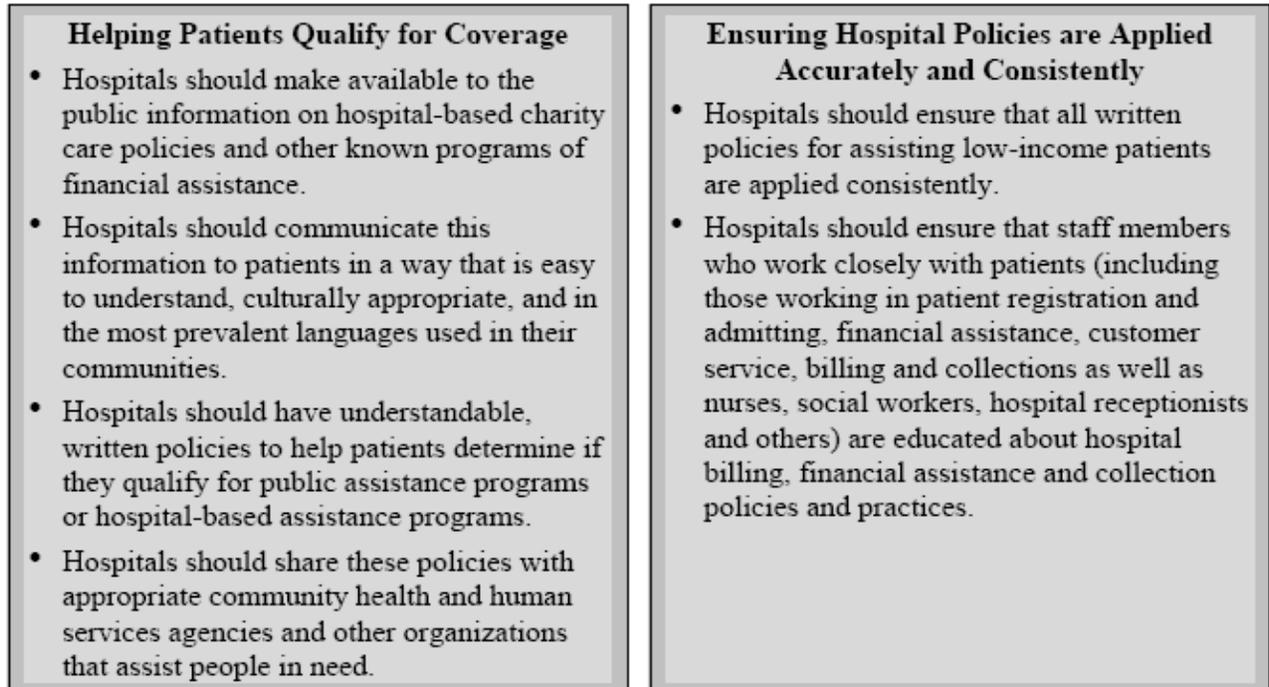


Figure 1

The 80th Texas Legislature passed Senate Bill 1731, also known as the “Consumer Access to Health Care Information” bill. It is a comprehensive measure that is designed to increase the transparency of health care costs and billing practices so that consumers can make informed health care decisions. All hospitals and physicians must comply with this law, effective September 1, 2007.⁷ The law requires hospitals and physicians to develop, implement, and enforce written policies that must address any discounts to the uninsured, and any discounting provided to a financially or medically indigent person or a written charity care policy. (Figure 2 and 3) The law requires posting notice of the availability of the policies in waiting areas, registration areas, and admission or business offices. The following tables contain the relevant laws:

⁶ American Hospital Association, *Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association* (American Hospital Association, 2004 [cited June 5 2008]); available from <http://www.aha.org/aha/content/2004/pdf/guidelinesfinalweb.pdf>.

See also, American Hospital Association. 2008. AHA Confirmation of Commitment. <http://www.aha.org/aha/content/2004/pdf/cocweblist.pdf>. (accessed June 5, 2008).

⁷ Senate Bill 1731 has become part of two statutes. See Texas Health and Safety Code. Title 4. Subchapter C. Sec. 324.101; Consumer Access to Health Care Information; available at <http://tlo2.tlc.state.tx.us/statutes/docs/HS/content/pdf/hs.004.00.000324.00.pdf>; and Occupations Code. Title 3. Health Professions Council; Billing Policies and Information; Physicians. Sec. 101.352; available at <http://tlo2.tlc.state.tx.us/statutes/docs/OC/content/html/oc.003.00.000101.00.htm#101.352.00>

**HEALTH AND SAFETY CODE
TITLE 4. HEALTH FACILITIES
CHAPTER 324. CONSUMER ACCESS TO HEALTH CARE INFORMATION**

SUBCHAPTER C. BILLING OF FACILITY SERVICES AND SUPPLIES

Sec. 324.101. FACILITY POLICIES. (a) Each facility shall develop, implement, and enforce written policies for the billing of facility health care services and supplies. The policies must address:

- (1) any discounting of facility charges to an uninsured consumer, subject to Chapter 552, Insurance Code;
- (2) any discounting of facility charges provided to a financially or medically indigent consumer who qualifies for indigent services based on a sliding fee scale or a written charity care policy established by the facility and the documented income and other resources of the consumer;
- (c) Each facility shall post in the general waiting area and in the waiting areas of any off-site or on-site registration, admission, or business office a clear and conspicuous notice of the availability of the policies required by Subsection (a).
- (g) A facility in violation of this section is subject to enforcement action by the appropriate licensing agency.

Sec. 324.102. COMPLAINT PROCESS. A facility shall establish and implement a procedure for handling consumer complaints, and must make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the complaint cannot be resolved informally, the facility shall advise the consumer that a complaint may be filed with the department and shall provide the consumer with the mailing address and telephone number of the department.

Figure 2

**OCCUPATIONS CODE
TITLE 3. HEALTH PROFESSIONS
SUBTITLE A. PROVISIONS APPLYING TO HEALTH PROFESSIONS GENERALLY
CHAPTER 101. HEALTH PROFESSIONS COUNCIL**

SUBCHAPTER H. BILLING

Sec. 101.352. BILLING POLICIES AND INFORMATION; PHYSICIANS. (a) A physician shall develop, implement, and enforce written policies for the billing of health care services and supplies. The policies must address:

- (1) any discounting of facility charges to an uninsured consumer, subject to Chapter 552, Insurance Code;
 - (2) any discounting of charges for health care services or supplies provided to an indigent patient who qualifies for services or supplies based on a sliding fee scale or a written charity care policy established by the physician;
 - (3) whether interest will be applied to any billed health care service or supply not covered by a third-party payor and the rate of any interest charged; and
 - (4) the procedure for handling complaints relating to billed charges for health care services or supplies.
- (b) Each physician who maintains a waiting area shall post a clear and conspicuous notice of the availability of the policies required by Subsection (a) in the waiting area and in any registration, admission, or business office in which patients are reasonably expected to seek service.

Figure 3

The Free Care Monitoring Project surveys were completed in January, 2008. During the course of recruiting community members to become a part of the project and having these members participate in the surveys, some community members joined the Subcommittee. Empowering community members by becoming part of a concrete advocacy project is one of the goals of the project designers at Community Catalyst.⁸

Just as the research was ending and final plans were being made for the project in 2008, Hurricane Ike hit the Gulf Coast. The devastation of the community by Ike impacted the organizations that had been surveyed and the Cancer Coalition members, as well as the Subcommittee members. The Cancer Coalition of Galveston County has not yet reconvened; however, the Subcommittee began to meet and continue to discuss plans for continuing the project in the summer of 2009.

⁸ Community Catalyst, *Free Care Monitoring Project: A How-to Guide for Advocates Seeking to Improve Hospital Free Care Programs*.

Information on the reporting of uncompensated care by Texas hospitals is complex and confusing. Research on this reporting of uncompensated care was informed by publications from the Texas Health and Human Services Commission. The 79th Texas Legislature directed the Health and Human Services Commission to study the components and assumptions used to calculate Texas hospitals' uncompensated care amounts.⁹ Deloitte Consulting was retained to provide a report on uncompensated care in Texas, which was completed in 2006.¹⁰ The 80th Texas Legislature created a Hospital Uncompensated Care Work Group in the General Appropriations Bill and in Senate Bill 10 to study and advise the Executive Commissioner of Health and Human Services on several aspects of uncompensated care.¹¹ The Work Group presented their findings and recommendations to the 81st Legislature in several formats. One report by the Work Group was particularly informative regarding uncompensated care in Galveston County.¹²

Limitations of the Surveys

The surveys conducted as part of the Galveston County Free Care Monitoring Project present results at a particular point in time. It is possible that the health care organizations surveyed would respond differently in 2009 and that the posting of signs on the availability of written policies on free or reduced cost care would have occurred by health care organizations. A few, but not most, of the monitors did not inquire about written policies on free or reduced cost care if the organization responded that no free care was available. In addition, the monitors asked “Do you provide free care?” and not “Do you provide charity care?” as the first question asked. It is possible that responders would have answered a question about charity care differently than a question about free care.

⁹ 79th Texas Legislature, Senate Bill 1, Article II, Rider 61.

¹⁰ Deloitte Consulting, *Rider 61: Texas Hospitals' Uncompensated Care* (Texas Health and Human Services Commission, 2006 [cited July 10 2009]); available from http://www.hhsc.state.tx.us/news/Rider_61_Report.pdf.

¹¹ 80th Texas Legislature, Senate Bill 10, Sec. 531.552.

¹² Texas Health and Human Services Commission, *Uncompensated Care in Texas: Moving toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs* (Texas Health and Human Services Commission, 2009 [cited July 25 2009]); available from <http://www.hhsc.state.tx.us/News/present80.asp>.



General Findings

Despite the diversity among the sites, the findings of the community monitors were surprisingly consistent. On the surveys, when asked: “Do you provide free care?” the response was “no,” or the question was not answered in 73 of 75 responses.¹³ Front line staff were universally unaware of a free care policy. However, even high level staff seemed taken aback by the phrase “free care.” Most often, staff assumed monitors wanted *applications* to determine eligibility, instead of *written policies*, even when asked repeatedly. At *all* of the Galveston County hospitals and clinics, monitors were told that policies were available *internally*, for possible discounts (not free care), but not available for the public. No written policies on free or reduced cost care were provided to the monitors for Galveston County hospitals and clinics during the survey period. However, Christus St. John Hospital in Harris County provided a written policy on charity care and the 4Cs Clinics provided a web-link to policies after the surveys were completed.

- During the surveys and site visits of Galveston area for-profit hospitals, one nonprofit hospital, Federally Qualified Health Care Centers, one public hospital and the public hospital clinics, all of the organizations reported that no free care was available.¹⁴
- No written policies on free or reduced cost care were provided to the monitors for Galveston County hospitals and clinics during the survey period. However, Christus St. John Hospital in Harris County provided a written policy on charity

¹³ There were two "yes" responses. One was a UTMB Hospital operator and the call was immediately transferred to the DAMP office. One was during a site visit to Christus St. John by a faith based monitor where a written policy was provided, though the answer was "no" or not answered in phone surveys.

¹⁴ There is one free clinic site in Galveston County at St. Vincent’s Episcopal House.

care and the 4Cs Clinics provided a web-link to policies after the surveys were completed.¹⁵

- All of the Galveston County hospitals and clinics reported that policies were available internally, for possible discounted care, but not available to the public.

¹⁵ For documents provided by Galveston County Health Department on February 28, 2008 see the following web links: <http://www.gchd.org/boards/GBboardpolicy.htm> and <http://www.gchd.org/4cs/eligible.htm>



Site Specific Findings and Recommendations

Mainland Medical Center

Mainland Medical Center is a 223 bed acute care community hospital located in Texas City.¹⁶ It is an HCA (Hospital Corporation of America) affiliate. HCA is the largest for profit hospital chain in the United States.¹⁷ In 2007, HCA facilities included 169 hospitals and 115 outpatient centers in twenty states and England.¹⁸

From November, 2007 to January, 2008, twelve surveys and site visits by community monitors were completed according to a template provided by Community Catalyst.¹⁹ At least two phone calls were made by English-speaking uninsured monitors and Spanish-speaking uninsured monitors to the main hospital phone number. Phone calls were also made by community agency staff to the social service and billing departments. Site visits were made by faith-based monitors to waiting rooms, registration and admitting areas, the emergency department and the billing department. When hospital staff appeared available, the monitors asked survey questions. All of the monitors were told that no free care was available and no written policies on free or reduced cost care were provided, although one monitor was told that written policies were available for internal use only. No signs were posted regarding the availability of written policies on free or reduced cost care.

¹⁶ Mainland Medical Center. 2008. Mainland Medical Center: Home. <http://www.mainlandmedical.com/>. (accessed June 5, 2008).

¹⁷ "Largest for-Profit Hospital Chains," *Modern Healthcare* 37, no. 10 (2007).

¹⁸ Hospital Corporation of America. 2008. HCA Fact Sheet. <http://www.hcahealthcare.com/CPM/CurrentFactSheet1.pdf>. (accessed June 5, 2008).

¹⁹ Community Catalyst is a national non-profit health care advocacy organization. For information on Community Catalyst, see their website at: http://www.communitycatalyst.org/about_us?id=001

All hospitals in Texas must comply with a law, effective September 1, 2007, known as “Consumer Access to Health Care Information.” Senate Bill 1731 passed in the 80th legislative session and is a comprehensive measure that is designed to increase the transparency of health care costs and billing practices so that consumers can make informed health care decisions. One part of the law requires hospitals to develop, implement, and enforce written policies that must address any discounts to the uninsured, and any discounting provided to a financially or medically indigent person or a written charity care policy. The law requires posting notice of the availability of the policies in waiting areas, registration areas, and admission or business offices.²⁰

Further research has shown that HCA does have a policy on charity care and financial discounts available on their website. According to the policy, there is “free care for any patient who receives non-elective treatment and whose household financial resources and/or income is at 200 percent or below the Federal Poverty Level.”²¹ The HCA policy was extensively detailed to members of Congress in 2004 during hearings on hospital billing and collection practices. Jack Bovender, HCA’s chief executive officer provided the following description of the policy:²²

“Our charity care program offers free or discounted nonelective care for those not covered by private insurance or government health assistance programs. For individuals with income up to 200 percent of the Federal poverty level, care is free. For those between 200 and 400 percent of the Federal poverty level, a sliding scale of discounts is applied.

To give you an idea of who benefits from these discounts [at 2004 federal poverty level guidelines], a family of four with a gross income of \$37,700 receives free care. At 400 percent above the poverty level, a family of four with a gross income of up to \$75,400 would qualify for a discount as high as 65 percent. Such a discount places the pricing into the same zone as those negotiated with some of the Nation’s largest health insurance providers.”

In an interview in 2007, HCA’s chairman and chief executive officer confirmed that the charity care program and sliding scale system that were mentioned in his Congressional testimony in 2004 were still in place.²³ Figure 4 was provided to Congress in 2004.

²⁰ See Texas Health and Safety Code. Title 4. Subchapter C. Sec. 324.101 and Occupations Code. Title 3. Health Professions Council; Billing Policies and Information; Physicians.

²¹ See Appendix B or Hospital Corporation of America. 2008. HCA’s Charity Care and Financial Discount Policy. <http://www.hcahealthcare.com/cpm/Uninsured%20web%20document.doc>. (accessed June 5, 2008).

²² House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *A Review of Hospital Billing and Collections Practices*, 108th Congress, June 24, 2004, 92.

²³ Kyle Grazier, "Interview with Jack O. Bovender," *Journal of Healthcare Management* 52, no. 4 (2007).

**HCA
PROPOSED SELF PAY/CHARITY DISCOUNT MATRIX
0-200% OF FPL/CHARITY AND
201-400% OF FPL/UNINSURED DISCOUNT**

Income Level	Account Balance						
	<\$1,000	\$1,001 - \$2,500	\$2,501 - \$5,000	\$5,001 - \$10,000	\$10,001 - \$25,000	\$25,001 - \$50,000	>\$50,000
0 - 200% of FPL – Charity	100%	100%	100%	100%	100%	100%	100%
200 - 300% of FPL	15%	25%	30%	35%	40%	45%	65%
300 - 400% of FPL	15%	20%	25%	30%	35%	40%	55%

Figure 4

Also in 2004, the American Hospital Association issued guidelines on hospital billing and collection practices.²⁴ These guidelines include the following statements: Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance. Hospitals should ensure that all written policies for assisting low-income patients are applied consistently. The hospital should communicate information about the policy in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in the community. The policy should be shared with appropriate community health and human services agencies and other organizations that assist people in need. All staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) should be educated about hospital billing financial assistance and collection policies and practices.

Mainland Medical Center is one of the hospitals that have signed a Confirmation of Commitment to the AHA’s Principles and Guidelines on Hospital Billing and Collections Practices.²⁵ Hospitals that have signed the confirmation pledge to adhere to the AHA principles and guidelines or work toward that goal in the near future. According to the Healthcare Financial Management Association, one of the communication methods reported by surveyed hospitals regarding financial assistance policies included placing full page ads in the newspaper related to charity care.²⁶

Texas hospitals must all complete a Cooperative Annual Survey issued by the Department of State Health Services (DSHS). Some hospitals must complete additional reports. The hospital surveys are available to the public through the Department of State Health Services.²⁷ The following data are from the 2006 and 2007 Annual Survey (Figure 5 and 6):

²⁴ American Hospital Association, *Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association*

²⁵ American Hospital Association. 2008. AHA Confirmation of Commitment. <http://www.aha.org/aha/content/2004/pdf/cocweblis.pdf>. (accessed July 29, 2009).

²⁶ Patient Friendly Billing Project, *Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients (Tools and References)* (Healthcare Financial Management Association, 2005 [cited August 29 2008]); available from <http://www.hfma.org/library/revenue/PatientFriendlyBilling/February2005Report.htm>.

²⁷ 2006 Annual Survey of Hospitals. 2007 Annual Survey of Hospitals.

<u>2006 Annual Survey of Hospitals: Mainland Medical Center</u>	
Charity Admissions (total number of Charity Inpatient only). (page 31)	95
Admissions (exclude newborns, include neonatal & swing admissions)	8,803
Charity Care Policy: Has your hospital governing body adopted a charity care policy statement and formal hospital eligibility system that it uses to determine eligibility for the charity care services it provides?	No
Uncompensated Care:	
Total Bad Debt Expense	\$32,011,070
Charity (Revenue Forgone at full established rates.) (page 15)	\$4,624,488
Cost to Charge Ratio Calculation:	
Divide 2005 Total Patient Care Operating Expenses	\$99,762,545
By 2005 Gross Patient Service Revenue	\$3,811,614,154
Cost to Charge Ratio .2614 (calculated by author)	
Total Estimated Costs of Charity Care Provided (page 41)	\$1,208,841

Figure 5

<u>2007 Annual Survey of Hospitals: Mainland Medical Center</u>	
Charity Admissions (total number of Charity Inpatient only). (page 11 of 32 Supplement)	NAV
Admissions (exclude newborns, include neonatal & swing admissions)	9,482
Charity Care Policy: Has your hospital governing body adopted a charity care policy statement and formal hospital eligibility system that it uses to determine eligibility for the charity care services it provides?	No
Uncompensated Care:	
Total Bad Debt Expense	\$32,656,614
Charity (Revenue Forgone at full established rates.) (page 17)	\$4,825,748
Cost to Charge Ratio Calculation:	
Divide 2006 Total Patient Care Operating Expenses	\$107,912,373
By 2006 Gross Patient Service Revenue	\$417,621,498
Cost to Charge Ratio .2568 (page 16 of 32 Supplement)	
Total Estimated Costs of Charity Care Provided (page 16 of 32 Supplement)	\$1,246,961

Figure 6

The definition of charity highlighted on the above Annual Hospital Surveys is:

Health care services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.^{28, 29}

The reporting of charity care under this definition suggests that there is a policy at Mainland Medical Center that addresses providing health care services free of charge and also that these services are based on financial criteria.

Summary of Findings and Recommendations for Mainland Medical Center

Findings:

- In twelve phone surveys and site visits to Mainland Medical Center, monitors were told that no free care was available and no written policies on charity care or financial assistance were provided.
- All hospitals in Texas must comply with a law, effective September 1, 2007, known as "Consumer Access to Health Care Information," that requires hospitals to develop, implement, and enforce written policies that must address any discounts to the uninsured, and any discounting provided to a financially or medically indigent person or a written charity care policy. The law requires posting notice of the availability of the policies in waiting areas, registration areas, and admission or business offices.
- Mainland Medical Center is part of Hospital Corporation of America (HCA).
- HCA has a charity care and financial discount policy available on their website and the CEO has testified to Congress about HCA's policy.
- Mainland Medical Center signed a pledge in 2004 to adhere to the American Hospital Association's guidelines and principles on hospital billing and collections that included making policies on charity care and financial assistance publicly available and applying them consistently.

Recommendations:

- Mainland Medical Center should adopt the charity care and financial assistance guidelines that were outlined by HCA during congressional testimony in 2004.

²⁸ Texas Department of State Health Services, *2006 Annual Survey of Hospitals* ([cited September 1 2009]); available from <http://www.dshs.state.tx.us/chs/hosp/Hosp2.shtm>.

²⁹ Texas Department of State Health Services, *2007 Annual Survey of Hospitals* ([cited September 1 2009]); available from <http://www.dshs.state.tx.us/chs/hosp/Hosp2.shtm>.

- Mainland Medical Center should, as required by the Texas Health and Safety Code, post notice in waiting areas, registration areas, and admission or business offices about the availability of written policies on charity care and financial discounts.
- Mainland Medical Center should, as evidence of their commitment to the American Hospital Association's guidelines and principles, apply the charity care and financial discount policy consistently. The hospital should communicate information about the policy in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in the community. The policy should be shared with appropriate community health and human services agencies and other organizations that assist people in need. All staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) should be educated about hospital billing financial assistance and collection policies and practices.
- Mainland Medical Center should publish its charity care and financial assistance policies annually in the Galveston County Daily News.

Galveston County Coordinated Community Clinics (4Cs)

Galveston County Coordinated Community Clinics (4Cs), located in Galveston and Texas City, are Federally Qualified Health Care Centers (FQHCs). These clinics provide primary health and dental care to people living in Galveston County. In 2006, the clinics served 17,723 people, including eighty-eight percent of whom were low-income (below 200% of the federal poverty level).³⁰ In order to be designated as a FQHC, clinics must adhere to certain requirements. One requirement is that certain primary health care services must be provided regardless of the patient's ability to pay.³¹

From November, 2007 to January, 2008, eighteen surveys and site visits by community monitors were completed according to an adaptation of a template provided by Community Catalyst.³² At least two phone calls were made by English-speaking uninsured monitors and Spanish-speaking uninsured monitors to the main clinic phone number for both Galveston and Texas City. Phone calls were also made by community agency staff to the registration and administrative departments. Site visits were made by faith-based monitors to waiting rooms of the Galveston and Texas City clinics. When clinic staff appeared available, the monitors asked survey questions. All of the monitors were told that no free care was available and no written policies on free or reduced cost care were provided, although one monitor was told that written policies were available for 4Cs staff only. A community agency monitor was provided an internet link to a table of financial discount guidelines based on the federal poverty level. Signs were posted regarding the provision of services regardless of ability to pay, the visit copayment charges, and that registration and financial screening are done to determine eligibility for discounted care. No signs were posted on the availability of written policies on free or reduced cost care.

After the surveys were completed, internet links were provided to 4Cs documents. All of these documents are now available on the 4Cs website.³³ These documents include: 1) an application for discounted services, 2) a table of financial discount guidelines based on the federal poverty level (2007 level), 3) a 4Cs patient financial guide that provides details on all copayments required, 4) the 4Cs collection policy that includes details on the use of collection agencies for unpaid bills, 5) a thorough list of medical fees and copayments, and 6) other related documents.

It is not clear, because FQHCs are not specifically mentioned in Senate Bill 1731, whether facilities such as Community Health Centers, must comply with the disclosure

³⁰ See: <http://www.gchd.org>

³¹ FQHCs receive Federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care, within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. See <http://bphc.hrsa.gov/>

³² Community Catalyst is a national non-profit health care advocacy organization. For information on Community Catalyst, see their website at: http://www.communitycatalyst.org/about_us?id=001

³³ For the application for discounted services see: <http://www.gchd.org/4cs/eligible.htm> For other policies see: <http://www.gchd.org/boards/GBboardpolicy.htm>

notices on the availability of written policies.³⁴ However, the new law, effective September 1, 2007, also requires that physicians licensed in Texas develop, implement, and enforce written policies for the billing of health care services that must address any discounting of charges for health care services provided to an indigent patient who qualifies for services based on a sliding fee scale or a written charity care policy established by the physician. The law also requires that physicians post a clear and conspicuous notice of the availability of the policies in the waiting area and in any registration, admission, or business office in which patients are reasonably expected to seek service.³⁵ To clarify this point, 4Cs already posts notices on the availability of discounted services but, at the time of the site visits, notices on the availability of written policies regarding such services were not observed. Such written policies are available on the 4Cs website, however.

Review of the 4Cs policies available on their website shows that 4Cs medical services are discounted 100% for uninsured people whose income is at or below the federal poverty level. For uninsured people whose income is at or below 200% of the federal poverty level, there is a sliding fee scale. The 4Cs Clinic Collection Policy states that for people at the zero pay level, charges are fully discounted; however, the patient is responsible for all copayments. Copayments are listed as either \$12 or \$15 for a medical or dental provider visit. Although a Galveston County resident will not be refused services based on ability to pay, if payment is not remitted at the time of service, patients will be billed. Patients with balances of 30 days and older will be sent a statement requesting immediate payment. If at the end of 120 days, the account remains outstanding without even a partial payment, the account (with the exception of County Indigent and Homeless) could be turned over to a collection agency for further collection efforts. The 4Cs Clinic Collection Policy also states that it is the responsibility of the staff to develop fair and reasonable guidelines for those accounts referred to collections to assure that patients who are homeless or financially screened as unable to pay are not turned over to a collection agency. Also, patients who contact the billing office and agree to a payment plan will not be turned over to collections unless the patient demonstrates repetitive disregard for their payment plan.³⁶

There is very little data on how many FQHCs charge a fee to people whose income is below the federal poverty level, what the amount of any such fees is, or how many community health centers use a collection agency. Section 330 of the Public Health Service Act authorizes community health centers and sets requirements. (Figure 7) The part of the Act that addresses requirements related to fee schedules states the following:³⁷

³⁴ In an April 25, 2008 email from Helen Kent Davis, Director of Government Affairs at the Texas Medical Association, compliance with the requirement is recommended since the law does not make exceptions for physicians who are employed at FQHCs.

³⁵ Occupations Code. Title 3. Health Professions Council; Billing Policies and Information; Physicians.

³⁶ For these policies see: <http://www.gchd.org/boards/GBboardpolicy.htm>

³⁷ Section 330 of the Public Health Service Act (k)(3)(G) is codified as 42 U.S.C. Sec. 254b available at <http://uscode.house.gov/uscode-cgi/fastweb.exe?search>

Section 330 of the Public Health Service Act (42 USCS § 254b)

(G) the center--

- (i) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay;
- (ii) has made and will continue to make every reasonable effort--
 - (I) to secure from patients payment for services in accordance with such schedules; and
 - (II) to collect reimbursement for health services to persons described in subparagraph (F) on the basis of the full amount of fees and payments for such services without application of any discount;
- (iii)
 - (I) will assure that no patient will be denied health care services due to an individual's inability to pay for such services; and
 - (II) will assure that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill the assurance described in subclause (I).

Figure 7

All FQHCs must also follow any other federal guidelines directed at community health centers. (Figure 8) For example, the Code of Federal Regulations specifies in more detail what community health centers must do in order to receive federal grants, including the following:³⁸

³⁸ 42 CFR 51c. 303 is available at http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr51c.303.pdf

42 CFR § 51c.303 Subpart C - Grants for Operating Community Health Centers

- (f) Have prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts adjusted on the basis of the patient's ability to pay. Provided, that such schedule of discounts shall provide for a full discount to individuals and families with annual incomes at or below those set forth in the most recent CSA Poverty Income Guidelines (45 CFR 1060.2) and for no discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines, except that nominal fees for services may be collected from individuals with annual incomes at or below such levels where imposition of such fees is consistent with project goals.

Figure 8

The Code of Federal Regulations uses the term “nominal fees” instead of the term “copayments” used by 4Cs, although these appear to be synonymous. The 4Cs Clinic Collection Policy is quite clear about the copayment policy. For people at the zero pay level, charges are fully discounted; however, the patient is responsible for all copayments. Copayments are listed as either \$12 or \$15 for a medical or dental provider visit. Although Galveston County residents are not refused services based on ability to pay, if payment is not remitted at the time of service, patients are billed. It is a little less clear what the 4Cs policy on using a collection agency is. After 30 days, patients with outstanding accounts are requested to make immediate payment, and if no payments or arrangements for payments are made after 120 days, then these accounts “could” be sent to a collection agency. 4Cs staff are responsible for the development of fair and reasonable collection practices that ensure patients who are following a payment plan, or patients who are homeless or financially screened as unable to pay are not turned over to a collection agency.³⁹ Whether cost sharing through copayments or nominal fees is an appropriate and useful tool for managing health care utilization among low-income populations is uncertain. On a practical level, the Texas Association of Community Health Centers (TACHC) reports that copayments at Community Health Centers in Texas are common, though specific data on copayments and on the use of collection agencies are not gathered by TACHC.⁴⁰ According to the National Association of Community Health Centers (NACHC), there are no statutory or regulatory requirements that FQHCs charge a nominal fee to people with incomes below the federal poverty level. The general rule appears to be that for those people whose income is below 100% of the

³⁹ For these policies see: <http://www.gchd.org/boards/GBboardpolicy.htm>

⁴⁰ In a telephone conversation on June 27, 2008 with Erica Swanholm at the Texas Association of Community Health Centers, this information was given to the author.

federal poverty level, a Federally Qualified Health Care Center need not charge anything, but Centers can choose to charge a nominal fee.⁴¹

In review, during eighteen phone surveys and site visits, monitors were told that no free care was available at 4Cs. According to 4Cs Clinic policy, charges for medical services are discounted 100% for uninsured people whose income is below the federal poverty level. However, all uninsured patients are responsible for copayments, listed as either \$12 or \$15, for a medical or dental provider visit. In general, patients are billed if payment cannot be made at the time of the visit. Although copayments are commonly expected at Community Health Centers in Texas, there is no statutory or regulatory requirement that such fees be charged. The language of the relevant legislation and rules allow for no payment (free care) for uninsured people whose income is below the federal poverty level.

Copayments and other forms of cost sharing have increased in health care in recent years and have included increased cost sharing among people with private and public health insurance as well as the uninsured.⁴² Cost sharing is not only an attempt to shift the ever growing expenditures on health care to patients, it is part of a theory about what drives health care's costs and who is responsible for illness. Often, cost sharing is linked to a general sense that people should bear some personal responsibility for their health and health care costs. Though this seems "intuitively attractive,"⁴³ there is a possibility of negative health effects when implementing cost sharing measures.⁴⁴

For example, people subject to cost sharing reduce their use of health care services and reduce health care spending. Cost sharing reduces unnecessary care but, of particular concern, is that it also reduces necessary care for serious symptoms or recommended preventive care.⁴⁵ In the RAND Health Insurance Experiment, a randomized trial with varying levels of cost sharing, copayments did not significantly harm the health of middle and upper-income people but did lead to poorer health for those with low incomes. The study found that among low-income adults and children, health status was considerably worse for those who had to make copayments than for those who did not. For example, copayments increased the risk of dying by about 10 percent for low-income adults at risk for heart disease because of hypertension.^{46,47} In a

⁴¹ In an email from Roger Schwartz, Legislative Counsel and Senior Director of State Affairs for the National Association of Community Health Centers, to the author on July 1, 2008, this clarification was provided.

⁴² Jessica S. Banthin and Didem M. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger Than 65 Years, 1996 to 2003," *Journal of the American Medical Association* 296, no. 22 (2006).

⁴³ Robert. Steinbrook, "Imposing Personal Responsibility for Health," *New England Journal of Medicine* 355, no. 8 (2006).

⁴⁴ Laura. D. Hermer, "Personal Responsibility: A Plausible Social Goal, but Not for Medicaid Reform," *Hastings Center Report* 38, no. 3 (2008).

⁴⁵ Mitchell D. Wong et al., "Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study," *American Journal of Public Health* 91, no. 11 (2001).

⁴⁶ Joseph P. Newhouse, *Free for All? : Lessons from the Rand Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1993).

recent study on cost sharing in the Medicare population, requiring a copayment of more than \$10 for screening mammography resulted in an eight percent decrease in this recommended test.⁴⁸ In a study of Medicaid patients in Utah, where eligibility is set at an income of about half of the federal poverty level, \$2 and \$3 copayments were associated with a significant reduction in physician visits.⁴⁹ One health professional cautions that “Because of the ubiquity of cost sharing, viewing it as an immutable fact of our health care system may be tempting. However, complacency with cost sharing in its present form is preventing vulnerable groups from receiving essential care.”⁵⁰ Several recent initiatives by both private and public health insurers have eliminated copayments for some medications, some preventive care, or for certain chronic conditions and have found that these initiatives lower the overall cost of health care.⁵¹

Though the definition of “affordability” can vary in policy debates, some recent findings regarding the affordability of health plans has shown that for households with incomes below 300 percent of the federal poverty level financial assets may often be negative.^{52,53} Competing demands among poor families (below 100 percent of the federal poverty level) for rent, food, child care, and other expenses may result in many of these families having difficulty meeting basic needs and a much lower chance of having any financial assets. This may be one reason that the use of collection agencies by Community Health Centers does not appear to be a common practice. In one survey of twenty health centers, only one center submitted unpaid bills to a collection agency.⁵⁴ In another community survey that included community health center patients, over two thirds of individuals reported that either having a current medical debt or having been referred to a collection agency affected whether they sought subsequent care; one quarter reported they no longer went to that site for care and about one fifth reported they delayed seeking care when needed.⁵⁵

⁴⁷ Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings" (Washington, D.C.: Center on Budget and Policy Priorities, 2005).

⁴⁸ The following study included over 350,000 women insured through Medicare. Amal N. Trivedi, William Rakowski, and John Z. Ayanian, "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans," *New England Journal of Medicine* 358, no. 4 (2008).

⁴⁹ Leighton Ku, Elaine Deschamps, and Judi Hilman, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," *Center on Budget and Policy Priorities* (November 2, 2004).

⁵⁰ R. Scott Braithwaite and Allison B. Rosen, "Linking Cost Sharing to Value: An Unrivaled yet Unrealized Public Health Opportunity," *Annals of Internal Medicine* 146, no. 8 (2007).

⁵¹ Vanessa Fuhrmans, "New Tack on Copays: Cutting Them," *The Wall Street Journal*, May 8 2007.

⁵² The following study used data from over 18,000 households from a survey conducted by the Federal Reserve Board, the 2004 Survey of Consumer Finances. Paul D. Jacobs and Gary Claxton, "Comparing the Assets of Uninsured Households to Cost Sharing under High-Deductible Health Plans," *Health Affairs* 27, no. 3 (2008).

⁵³ Christine Barber and Michael Miller, *Affordable Health Care for All: What Does Affordable Really Mean?* (Community Catalyst, 2007 [cited July 30, 2008]; available from http://www.communitycatalyst.org/doc_store/publications/affordable_health_care_for_all_apr07.pdf).

⁵⁴ Michael K. Gusmano, Gerry Fairbrother, and Heidi Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs* 21, no. 6 (2002).

⁵⁵ Thomas P. O'Toole, Jose J. Arbelaez, and Robert S. Lawrence, "Medical Debt and Aggressive Debt Restitution Practices: Predatory Billing among the Urban Poor," *Journal of General Internal Medicine* 19, no. 7 (2004).

Medical debt and actions by collection agencies can affect overall financial security. In one national survey, even relatively small amounts of medical debt, \$500 or less, created housing problems and contributed to housing insecurity. People who had been contacted by a collection agency were more likely to report that the debt resulted in housing problems. Among those who make or advise others about lending decisions, there is some evidence that a consensus is developing that medical debt should be considered differently from other types of personal debt. If a medical debt is pursued by a collection agency, this distinction might not be identifiable.⁵⁶

The National Association of Community Health Centers appears to recognize that cost sharing can reduce utilization for medically necessary services for low income patients. In a letter to the Centers for Medicaid and Medicare Services (CMS) regarding recent changes allowing cost sharing in the Medicaid population, the National Association of Community Health Centers has requested that “CMS urge states not to apply such cost sharing to the receipt of FQHC services.”⁵⁷ In Texas, over half of Medicaid beneficiaries have incomes below the federal poverty level. In other words, most of these individuals are in the same income category from whom \$10 or \$12 copayments are expected at 4Cs.⁵⁸ Similarly, in a report prepared for the National Association of Community Health Centers, cost sharing in the Medicaid population is recognized to have a potentially negative effect on the health seeking behavior of patients who may not be able to afford copayments.⁵⁹ In a report on economic stress and its impact on community health centers and their patients, the authors note that the “extreme sensitivity to cost in the health-seeking behavior of the low-income population should be a matter of concern” and that “fears about inability to make even modest copayments” are particularly prevalent for the newly uninsured.⁶⁰

⁵⁶ Robert Seifert, *Home Sick: How Medical Debt Undermines Housing Security* (The Access Project, 2005 [cited August 15 2008]); available from http://www.accessproject.org/adobe/home_sick.pdf.

⁵⁷ Roger Schwartz, *Re: Medicaid Program; Premiums and Cost Sharing* [Letter] (National Association of Community Health Centers, March 24, 2008); available from http://www.nachc.com/client/documents/NACHC_Comments_DRA_CostSharing_PremiumFINAL.pdf.

⁵⁸ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 6th Edition* (Texas Health and Human Services Commission, January 2007 2007 [cited July 30, 2008]); available from <http://www.hhsc.state.tx.us/Medicaid/reports/PB6/PinkBookTOC.html>.

⁵⁹ Sara Wilensky and Mara McDermott, "Unkindest Cuts: The Impact of State Medicaid Reductions on Health Centers and Their Patients," in *State Policy Report #5* (Washington, D.C.: The National Association of Community Health Centers, 2005).

⁶⁰ Sara Rosenbaum, Peter Shin, and Julie Darnell, *Economic Stress and the Safety Net: A Health Center Update* (Kaiser Commission on Medicaid and the Uninsured, June 2004 [cited August 28 2008]); available from <http://www.kff.org/uninsured/upload/Economic-Stress-and-the-Safety-Net-A-Health-Center-Update.pdf>.

Summary of Findings and Recommendations for Galveston County Coordinated Community Clinics (4Cs)

Findings:

- In eighteen phone surveys and site visits to 4Cs in Galveston and Texas City, monitors were told that no free care was available and no written policies on charity care or financial assistance were provided. An internet link to a table of discounted care was provided.
- Signs were posted regarding the availability of discounted services, though not on the availability of written policies regarding such services.
- After the surveys were completed, an internet link was provided to the following documents: 1) an application for discounted services, 2) a table of financial discount guidelines based on the federal poverty level (2007 level), 3) a 4Cs patient financial guide that provides details on all copayments required, 4) the 4Cs collection policy that includes details on the use of collection agencies for unpaid bills, 5) a thorough list of medical fees and copayments, and 6) other related documents.
- According to state law effective September 1, 2007, physicians licensed in Texas must develop, implement, and enforce written policies for the billing of health services that must address any discounting of charges for health care services provided to an indigent patient who qualifies for services based on a sliding fee scale or a written charity care policy. The law also requires that physicians post a clear and conspicuous notice of the availability of the policies in the waiting area and in any registration, admission, or business office in which patients are reasonably expected to seek service.
- 4Cs is a Federally Qualified Health Care Center and is required by federal law to see patients regardless of their ability to pay.
- Medical services at 4Cs are discounted 100% for uninsured people whose income is below the federal poverty level. Services are discounted on a sliding fee scale for people with incomes below 200% of the federal poverty level. All uninsured people are responsible for a copayment for services. For example, the copayment is \$12 or \$15 for a medical or dental provider visit.
- Requiring a copayment for uninsured people whose income is below the federal poverty level appears to be a common practice in community health centers in Texas. However, cost sharing, such as copayments, has been shown to reduce necessary care with a greater harmful effect among poor people. The National Association of Community Health Centers has urged the federal government not to require copayments at community health centers for Medicaid patients, most of whom have incomes below the federal poverty level.
- Community health centers are not required by any laws or regulations to charge any fees to people whose income is below the federal poverty level.

- The use of a collection agency by community health centers does not appear to be a common practice. There is some evidence that people whose accounts are referred to a collection agency are much less likely to return to that site for care as well as delay obtaining health care. Actions by collection agencies can affect overall financial security leading to housing problems and bad credit.

Recommendations:

- 4Cs should continue to post notices on the availability of discounted services. 4Cs should also (as required by physicians in the Texas Occupations Code effective September 1, 2007) post notice on the availability of written policies on financial discounts.
- 4Cs should either not impose copayments for health services on people whose income is below the federal poverty level, or allow waiving of these copayments without incurring a medical debt.
- 4Cs should not use aggressive billing practices, such as turning over accounts to a collection agency.
- 4Cs should publish its policies regarding the availability of free or discounted health care services annually in the Galveston County Daily News.

The University of Texas Medical Branch

The University of Texas Medical Branch in Galveston was established in 1891 as the first academic health center in Texas and is among the oldest in the nation. UTMB has a distinguished history of training a skilled health professions work force, advancing medical knowledge through research, and treating patients from throughout the state. UTMB is a component of the University of Texas System. The hospital and clinics are state owned public facilities. Despite the challenges posed by Hurricane Ike, UTMB currently reports a bed count of 310, eighty clinics providing primary and specialty services, an almost completely restored research enterprise, and responsibility for over two thousand students and physicians in training.⁶¹

From November 2007 to January 2008, thirty-nine surveys and site visits of UTMB hospital and clinics by community monitors were completed according to a template provided by Community Catalyst.⁶² The purpose of the surveys was to obtain information on free and reduced cost health care. At least two phone calls were made by English-speaking uninsured monitors and Spanish-speaking uninsured monitors to the main hospital phone number. A call was made to the main hospital phone number at different times of the week (a weekday and an evening call). Phone calls were also made by community agency staff to the social services department, the hospital billing department, financial counseling and the Demand Access Management Program (DAMP). Monitors recorded answers to survey questions from each phone call, including information on surveys from phone call transfers. Site visits were made by faith-based monitors to hospital waiting rooms, registration and admitting areas, the emergency department and the billing department. Site visits were also made to UTMB clinics in Galveston and on the Mainland including:

1. Primary Care Pavilion A (Harborside Drive)
2. Primary Care Pavilion B (Harborside Drive)
3. University Hospital Clinics
4. Stewart Road Clinic
5. Ursuline (39th Street) Clinic
6. Family Health Care Center in Texas City (6400 Memorial Drive)
7. Pediatric Clinic in Texas City (6400 Memorial Drive)

During site visits, when hospital or clinic staff appeared available, the monitors asked survey questions.

In thirty-eight of thirty-nine phone calls and site visits, monitors were told that no free care was available and no written policies on free or reduced cost care were provided. In one phone call to the hospital main number, the monitor was told that free care is available and the call was immediately transferred to the DAMP office. During one phone call, a community monitor was told that discounted care is available based on

⁶¹ See <http://www.utmb.edu/facts/sections/profile.asp>

⁶²Community Catalyst, *Free Care Monitoring Project: A How-to Guide for Advocates Seeking to Improve Hospital Free Care Programs*.

federal poverty guidelines, though the responder was not sure this policy could be shared with the public. The monitor was told that a policy would be emailed if disclosure of the policy was approved. No email was received. No signs were posted regarding the availability of written policies on free or reduced cost care at any of the hospital or clinic sites.

In twenty-six of the thirty-nine phone calls and site visits, monitors spoke to or were referred to personnel in the DAMP office. (Figure 9) DAMP office personnel often did not know whether UTMB provides any free care or responded that there is no free care at UTMB. Several monitors were told that discounted care is available but there is no written policy regarding financial assistance. During several surveys, monitors were told to “go to your county,” even though all of the monitors were Galveston County residents, or monitors were told to go to 4Cs clinic. (Figure 10) A DAMP administrator described the DAMP office as a “processing center” with no written policies for patients, referring physicians, or even the DAMP office itself. Decisions about who is accepted for possible discounted care, according to the DAMP administrator, are not known by DAMP personnel but seem to be based on the needs of the clinic for training and educational purposes. One DAMP administrator said, “There is nothing written on a piece of paper about who will be approved.” The following two charts depict the results of the surveys.

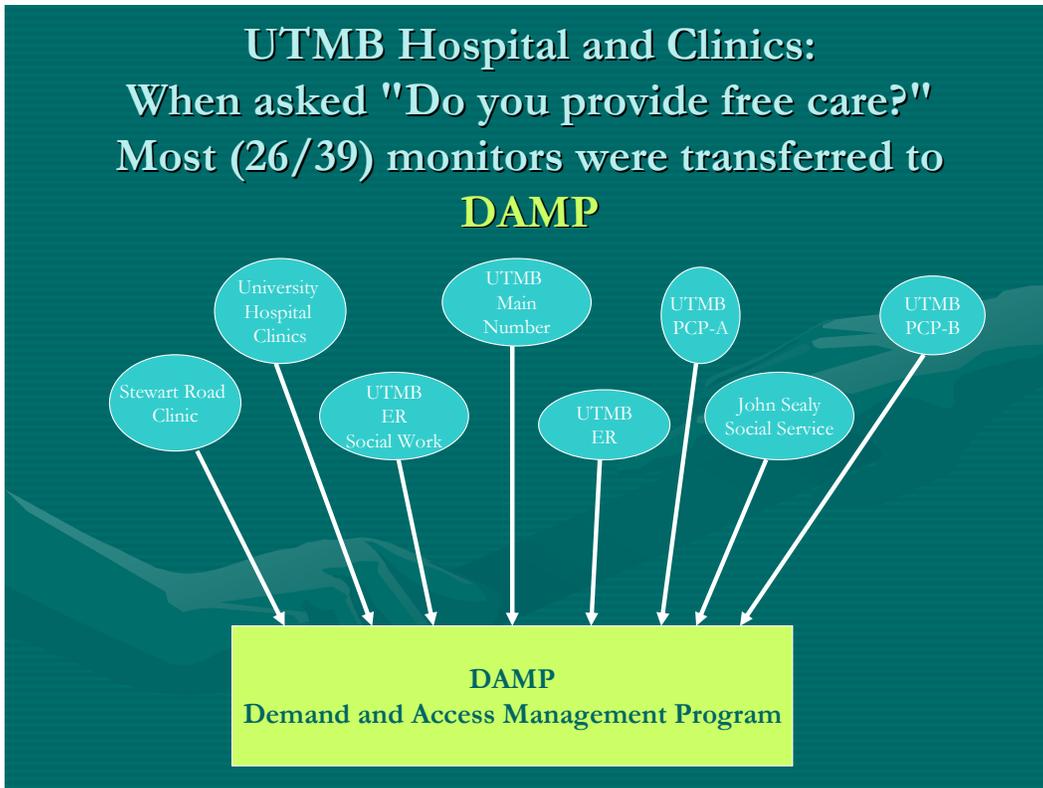


Figure 9

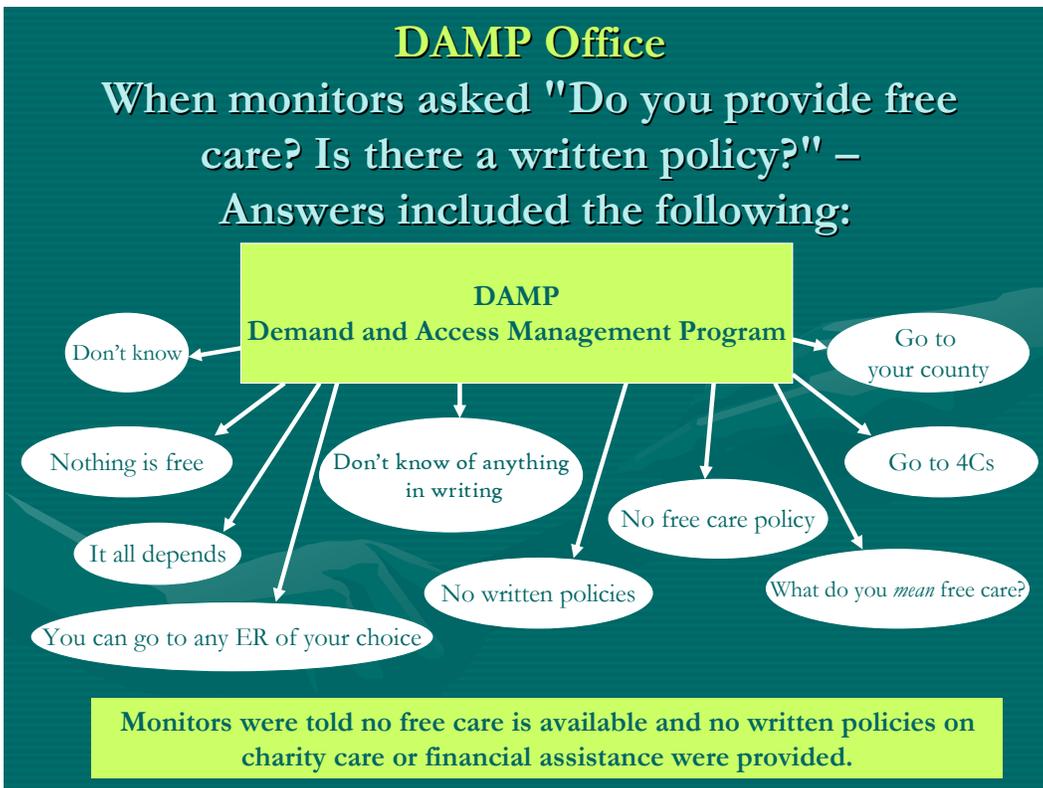


Figure 10

At the UTMB clinics, monitors were told that UTMB does not provide free care and that patients who cannot pay or do not have health insurance are referred to the 4Cs clinic. Referrals from the UTMB clinics were also made to the Jesse Tree, Chamber of Commerce, or a clinic not affiliated with UTMB on the Galveston seawall. Some monitors were told that there is an application for health care services online. Hospital personnel reported there is “absolutely no free care” and everyone must be financially screened to determine a copayment. No written policies were made available to the monitors regarding eligibility for charity care or financial assistance. No charity care or financial assistance policies were available online. An “Application for Financial Assistance” was available online.⁶³

In comparison, in a national survey of more than 100 hospital executives on charity care issues, by the health care consulting firm PricewaterhouseCoopers, most hospitals communicated charity care policies on admission and over half of hospitals posted their charity care policies online. Figure 11 shows how hospitals communicated their

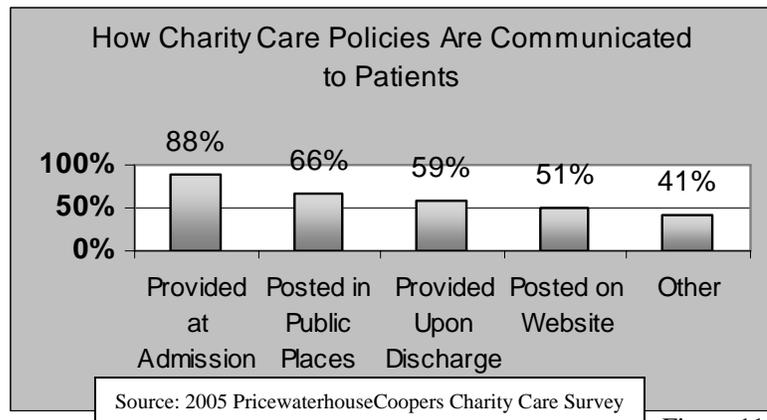


Figure 11

charity care policies to patients in the survey. While hospital executives were fearful that publishing charity care policies could “open the floodgates for charity care patients,” most hospitals had recently expanded eligibility for charity care.⁶⁴

The American Hospital Association recognized that hospital charity care and financial assistance policies had come under the scrutiny of the public in recent years. In 2004, the American Hospital Association issued guidelines on hospital billing and collection practices.⁶⁵ These guidelines include the following statements: Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance. Hospitals should ensure that all written policies for assisting low-income patients are applied consistently.

The University of Texas Medical Branch Hospitals signed a Confirmation of Commitment to the American Hospital Association’s Principles and Guidelines on Hospital Billing and Collection Practices. Hospitals that have signed the confirmation pledge to adhere to the AHA principles and guidelines or work toward that goal in the

⁶³ University of Texas Medical Branch, *Application for Financial Assistance* (2009 [cited August 19 2009]); available from <http://www.utmb.edu/financialcounseling/Forms/index.htm>.

⁶⁴ PricewaterhouseCooper Health Research Institute, "Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape," (2005), 15,24-25.

⁶⁵ American Hospital Association, *Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association*

near future.⁶⁶ According to the Healthcare Financial Management Association, one of the communication methods reported by surveyed hospitals regarding financial assistance policies included placing full page ads in the newspaper related to charity care.⁶⁷

Texas hospitals must all complete a Cooperative Annual Survey issued by the Department of State Health Services (DSHS). The annual survey represents the state's "only comprehensive source of information on issues such as uncompensated care and hospital utilization trends."⁶⁸ The hospital surveys are available by public request through the Texas Department of State Health Services. The following data in figures 12 and 13 are from the 2006 and 2007 Annual Surveys:⁶⁹

⁶⁶ American Hospital Association. 2008. AHA Confirmation of Commitment. <http://www.aha.org/aha/content/2004/pdf/cocweblist.pdf>. (accessed July 29, 2009).

⁶⁷ Patient Friendly Billing Project, *Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients (Tools and References)*.

⁶⁸ 2008 Annual Survey of Hospitals form, page 1.

⁶⁹Total charity care charges are not consistent on the survey. Inconsistencies in the Annual Survey have been noted in the following report: Deloitte Consulting, *Rider 61: Texas Hospitals' Uncompensated Care*.

<u>2006 Annual Survey of Hospitals: University of Texas Medical Branch*</u>	
Charity Admissions (total number of Charity Inpatient only).	2,534
Admissions (exclude newborns, include neonatal & swing admissions)	33,378
Charity Care Policy: Has your hospital governing body adopted a charity care policy statement and formal hospital eligibility system that it uses to determine eligibility for the charity care services it provides?	Yes
If reported "Yes," does your charity care policy address care for the "Financially Indigent?"	Yes
If reported "Yes," does your charity care policy address care for the "Medically Indigent?"	Yes
Uncompensated Care	
Inpatient and Outpatient Bad Debt Charges (page 24):	
Inpatient Bad Debt Charges	\$68,196,960
Outpatient Bad Debt Charges	\$802,533
Total Bad Debt Charges (pages 15 and 24)	\$68,999,493
Charity (Revenue Forgone at full established rates) (page 15)	\$161,265,948
<i>Charity care defined as: Health services that were never expected to result in cash inflows. Charity care results from a providers policy to provide health care services free of charge to individuals who meet certain financial criteria.</i>	
Inpatient and Outpatient Charity Charges (page 24):	
Inpatient Charity Charges	\$185,363,459
Outpatient Charity Charges	\$155,056,727
Total Charity Charges (page 24)	\$340,420,186
Total Charity Care Charges (page 40)	\$190,837,892
Cost to Charge Ratio Calculation (page 40):	
Divide 2005 Total Patient Care Operating Expenses	\$681,244,992
By 2005 Gross Patient Service Revenue	\$1.220,143,408
Cost to Charge Ratio .5583	
Total Estimated Costs of Charity Care Provided	\$106,550,884
Total Payments Received for Charity Care Provided	\$8,040,225
Estimated Unreimbursed costs of Charity Care Provided	\$98,510,659
<i>*Inaccuracies and inconsistencies are as reported (Page numbers refer to 2006 Annual Survey)</i>	

Figure 12

<u>2007 Annual Survey of Hospitals: University of Texas Medical Branch*</u>	
Charity Admissions (total number of Charity Inpatient only).	3,920
Admissions (exclude newborns, include neonatal & swing admissions)	29,472
Charity Care Policy: Has your hospital governing body adopted a charity care policy statement and formal hospital eligibility system that it uses to determine eligibility for the charity care services it provides?	Yes
Uncompensated Care	
Inpatient and Outpatient Bad Debt Charges (page 24):	
Inpatient Bad Debt Charges	\$79,197,650
Outpatient Bad Debt Charges	\$787,692
Total Bad Debt Charges (pages 17 and 5 Supplement)	\$79,985,342
Charity (Revenue Forgone at full established rates) (page 17)	\$152,955,359
<i>Charity care defined as: Health services that were never expected to result in cash inflows. Charity care results from a providers policy to provide health care services free of charge to individuals who meet certain financial criteria.</i>	
Inpatient and Outpatient Charity Charges (page 5 Supplement):	
Inpatient Charity Charges	\$88,989,642
Outpatient Charity Charges	\$113,395,411
Total Charity Charges	\$202,385,053
Cost to Charge Ratio Calculation (Estimated by author**):	
Divide 2006 Total Patient Care Operating Expenses	\$700,100,850
By 2006 Gross Patient Service Revenue	\$1.184,977,277
Cost to Charge Ratio .5908	
Total Estimated Costs of Charity Care Provided***	
Using Charity Charges (page 17)	\$90,366,026
Using Charity Charges (page 5 Supplement)	\$119,569,089
<p><i>*Inaccuracies and inconsistencies are as reported.</i></p> <p><i>**Estimate based on 2006 Annual Survey methodology.</i></p> <p><i>***Neither estimate appears comparable to the 2006 Survey since there were three different reports of charity care charges in that survey and only two differing reports of charity care charges in the 2007 survey. The missing charity care charge would be needed for a comparable estimate.</i></p> <p><i>(Page numbers refer to 2007 Annual Survey)</i></p>	

Figure 13

Although the monitors were told that no free care is available at UTMB and no written charity care or financial assistance policies were provided, charity care is reported annually by UTMB to the Texas Department of State Health Services. Charity care and bad debt are components of “uncompensated care,” a term that is recognized as inexact, at best. For example, uncompensated care reporting in Texas has been referred to as “plagued by nuance and inconsistency.”⁷⁰ Nationally, uncompensated care has been

⁷⁰ Ibid.

called the “mysterious mélange of ‘charity care’ and ‘bad debts,’ whose definitions have long included much art as well as science—and lots of arbitrary convention.”⁷¹ The concept of uncompensated care is that it is care given where no payment is received. Designating such care as charity has an enormous impact on people as compared to designating such care as bad debt.⁷² Charity care involves health care services for which no payment is expected. It results from an organization’s policy to provide health care services free of charge to individuals who meet certain financial criteria. In contrast, bad debt results from uncollected revenue that a hospital expects to receive.⁷³

UTMB reports to the Texas Department of State Health Services that there is a charity care policy and that it includes a formal eligibility system. Senate Bill 1731 passed in the 80th legislative session and is a comprehensive measure that is designed to increase the transparency of health care costs and billing practices so that consumers can make informed health care decisions. All hospitals in Texas must comply with this law, effective September 1, 2007, known as “Consumer Access to Health Care Information.” One part of the law requires hospitals to develop, implement, and enforce written policies that must address any discounts to the uninsured, and any discounting provided to a financially or medically indigent person or a written charity care policy. The law requires posting notice of the availability of the policies in waiting areas, registration areas, and admission or business offices.⁷⁴

In two-thirds of the surveys, monitors spoke to personnel in the DAMP office. The DAMP office is reported to have closed in August of 2008.⁷⁵ The office has also been reported to have closed following Hurricane Ike.⁷⁶ According to the UTMB Handbook of Operating Procedures updated in October of 2008, the DAMP office facilitates requests for unsponsored non-emergent medical care.⁷⁷ There appears to be conflicting information on the status of the DAMP office. There are, however, at least two reasons why research on the DAMP office may be important to the Free Care Monitoring Project even if it is now closed. The first is that the DAMP office, in existence since 1998, has played an important role in the provision of health care for uninsured persons and was perceived by most UTMB survey responders to be the place to refer all questions regarding free or reduced cost care. The second is that the management of the DAMP office may provide a clue to the future approach by UTMB of

⁷¹ Bruce C. Vladeck, "Paying for Hospitals' Community Service," *Health Affairs* 25, no. 1 (2006).

⁷² PricewaterhouseCooper Health Research Institute, "Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape."

⁷³ Community Catalyst, "Not There When You Need It: The Search for Free Hospital Care."

⁷⁴ See Texas Health and Safety Code. Title 4. Subchapter C. Sec. 324.101 and Occupations Code. Title 3, Health Professions Council; Billing Policies and Information; Physicians.

⁷⁵ Melissa del Bosque, "Storm over UTMB: What Happened to the Heart of Texas Health Care?," *Texas Observer*, March 20 2009. <http://www.texasobserver.org/article.php?aid=2991> (accessed July 29, 2009).

⁷⁶ Andrew Kreighbaum, "UTMB to Request Relief Aid Advance," *The Daily Texan*, December 10, 2008.

⁷⁷ UTMB Handbook of Operating Procedures. Policy 9.8.2. Financial Responsibility of UTMB Patients including Financial and Medical Indigent Application Process. 10/17/08 Reviewed with changes. http://www.som.utmb.edu/faculty/IHOP_recent_changes.pdf (accessed August 19, 2009.)

dealing with uninsured people. For example, since Hurricane Ike, several sources have reported that UTMB is not providing health care services to any uninsured patients.^{78,79,80}

Research on the DAMP office is difficult since, according to administrative staff answering survey questions, in over ten years of operating the program no written policies for patients, referring physicians, or even the DAMP office itself were created regarding who would be accepted for care. Not always appreciated is that the DAMP office has functioned in three tiers. One tier involves financial screening and requiring payments. The second tier involves departmental caps on the number of uninsured patients accepted. The third involves referral judgments.⁸¹

According to DAMP Administrative staff answering survey questions, in over ten years of operating the program, no written policies for patients, referring physicians, or even the DAMP office itself were created regarding who would be accepted for care.

Concerning the first tier of financial screening and requiring payments, there has been some information relayed to the public through UTMB official announcements but most of the available information has been communicated by investigative reports. When the DAMP office was created in 1998, patients not covered by any payer or county contract, those requesting services that were not covered, or patients from contract counties seeking primary care services at UTMB were required to pay 25 percent of the standard reimbursement prior to care if their income was documented to be below 250 percent of the poverty index. An additional 25 percent would be billed. If their income was above 250 percent of the poverty index, they were asked to pay half of the standard reimbursement prior to care. The balance would be billed.^{82,83,84} According to these

⁷⁸ Ralph Haurwitz, "Future of Patient Care at UT Medical Branch Uncertain," *Austin American-Statesman*, February 8, 2009.

⁷⁹ Rhiannon Meyers, "UTMB Not Seeing Uninsured Patients after Ike," *Galveston County Daily News*, December 21, 2008.

⁸⁰ Rhiannon Meyers, "County May Send Indigent Care Patients to Houston," *Galveston County Daily News*, January 16, 2009.

⁸¹ Jim Molpus, Kathryn Mackenzie, and John Commins, *Help the Uninsured (without Going Broke)* (August 11, August 11, 2008 [cited June 7 2009]); available from http://www.healthleadersmedia.com/content/216726/page/1/topic/WS_HLM2_MAG/Help-the-Uninsured-Without-Going-Broke.html.

⁸² John D. Stobo, *A Message from President John D. Stobo: The Demand and Access Management Program* (University of Texas Medical Branch, 1998 [cited October 2 2006]); available from <http://www.UTMB.edu/president/damphome.htm>.

⁸³ University of Texas Medical Branch, *The Demand and Access Management Program Fact Sheet* (University of Texas Medical Branch, 1998 [cited October 2 2006]); available from <http://www.UTMB.edu/president/facts.htm>.

rules, the patients with the lowest income would be responsible for an upfront payment of 25 percent of the standard charge and would be billed for a total of 50 percent of the standard charge.

In 2003, the DAMP office required people without insurance to pay \$80 before seeing a doctor, unless they earned less than 185% of the federal poverty level, in that case they qualified for a discounted fee of about \$30.⁸⁵ The most recent “Deposit Guide for Services at UTMB” is below and is available currently on the UTMB website.⁸⁶ (Figure 14) There are no eligibility criteria available on the website and no charity care or financial assistance policies. There are financial assistance application forms available. Patients who fall under the categories of “50% Pay” and “0% Pay” are required to pay \$40 in advance of any treatment, however, it is unknown whether these discounts apply to people on the basis of a specified income level.

DEPOSIT GUIDE FOR SERVICES AT UTMB

The deposit amount is a fee **PAID IN ADVANCE** applied toward your service received at UTMB. The deposit amounts are listed in categories which are Full Pay, 50% Pay, or 0% Pay. The financial screening process identifies which category you would fall under. The deposit schedule should be used as a general guide for each patient to give them an estimate of what could be required for any particular service at UTMB. **(Deposit is only a partial payment toward the cost of a service and patients will be balanced billed for the remaining costs of the service.)** If the physician makes a determination that you need a procedure or surgery, staff in that area will inform you of what your specific deposit amount will be at the time. *Current Registration does not ensure appointments to all UTMB Clinics.* Fees are subject to change at any time.

<u>SERVICE OR PROCEDURE</u>	<u>FULL PAY*</u>	<u>50% PAY**</u>	<u>0%</u>
<u>OUTPATIENT VISIT SERVICE</u>			
Office Visit	\$ 80.00	\$ 40.00	\$ 40.00

*Full Pay will be balanced billed for the remainder of their services.
 **50% pay will receive 50% discount on all services. Deposits apply to the remaining 50% balance.

Figure 14

In 2006 UTMB’s Chief Financial Officer reported that, on average, Medicaid pays about 37 percent of the regular rate and Medicare pays about 46 percent, with private commercial insurance paying about 51 percent.⁸⁷ In other words, people who fall under the “50% Pay” and “0% Pay” levels actually are charged more than people with health insurance coverage through Medicaid and Medicare and people in these categories are charged about the same as people who have private health insurance. (Figure 16)

The 80th Legislature in Texas created a Hospital Uncompensated Care Work Group to study and give advice on standardizing a definition of uncompensated care and on other facets of uncompensated care. The Work Group found that up to five different

⁸⁴ Joanna Charles Bremer, "UTMB's History of Care for the Indigent" (University of Texas Medical Branch, 2008), 5-6. Unpublished manuscript.

⁸⁵ Bernard Wysocki, "The Rules: At One Hospital, a Stark Solution for Allocating Care," *Wall Street Journal*, September 23, 2003.

⁸⁶ University of Texas Medical Branch, *Deposit Guide for Services at UTMB* (University of Texas Medical Branch, 2009 [cited August 19, 2009]); available from <http://www.UTMB.edu/financialcounseling/Forms/index.htm>.

⁸⁷ Kelly Hawes, "Woman: No One Looking out for Middle Class," *Galveston County Daily News*, May 3, 2006.

reports are completed by hospitals regarding uncompensated care and that these reports use common terms such as “charity care,” which are defined in different ways.⁸⁸ However, on one section of the Annual Hospital Survey reported above for the years 2006 and 2007, the definition of charity care is straightforward:

Health care services that were never expected to result in cash inflows. Charity care results from a provider’s policy to provide health care services free of charge to individuals who meet certain financial criteria.^{89 9091}

If this definition is used, it is not clear that any health care services adhering to DAMP payment procedures and the Deposit Guide for Services at UTMB could be referred to as charity care. Both the DAMP guidelines and the deposit guide include substantial payment requirements directed at poor patients, therefore there appear to be no “services free of charge.” Yet, under this definition of charity care, the 2006 Annual Survey for UTMB included \$161,265,948⁹² in charity charges and, in 2007, \$152,955,359⁹³ was reported in charity charges.

The one case where no hospital can refuse to care for uninsured patients regardless of ability to pay is when there is a condition deemed to be a medical emergency. A federal law, the Emergency Medical Treatment and Labor Act, mandates that all Medicare-participating hospitals with emergency departments must provide stabilizing care to patients with an emergency condition, regardless of ability to pay. This law does not prohibit hospitals from billing patients for emergency treatment.⁹⁴

⁸⁸ Texas Health and Human Services Commission, *Uncompensated Care in Texas: Moving toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs*.

⁸⁹ *Ibid.*

⁹⁰ Texas Department of State Health Services, *2006 Annual Survey of Hospitals*.

⁹¹ Texas Department of State Health Services, *2007 Annual Survey of Hospitals*.

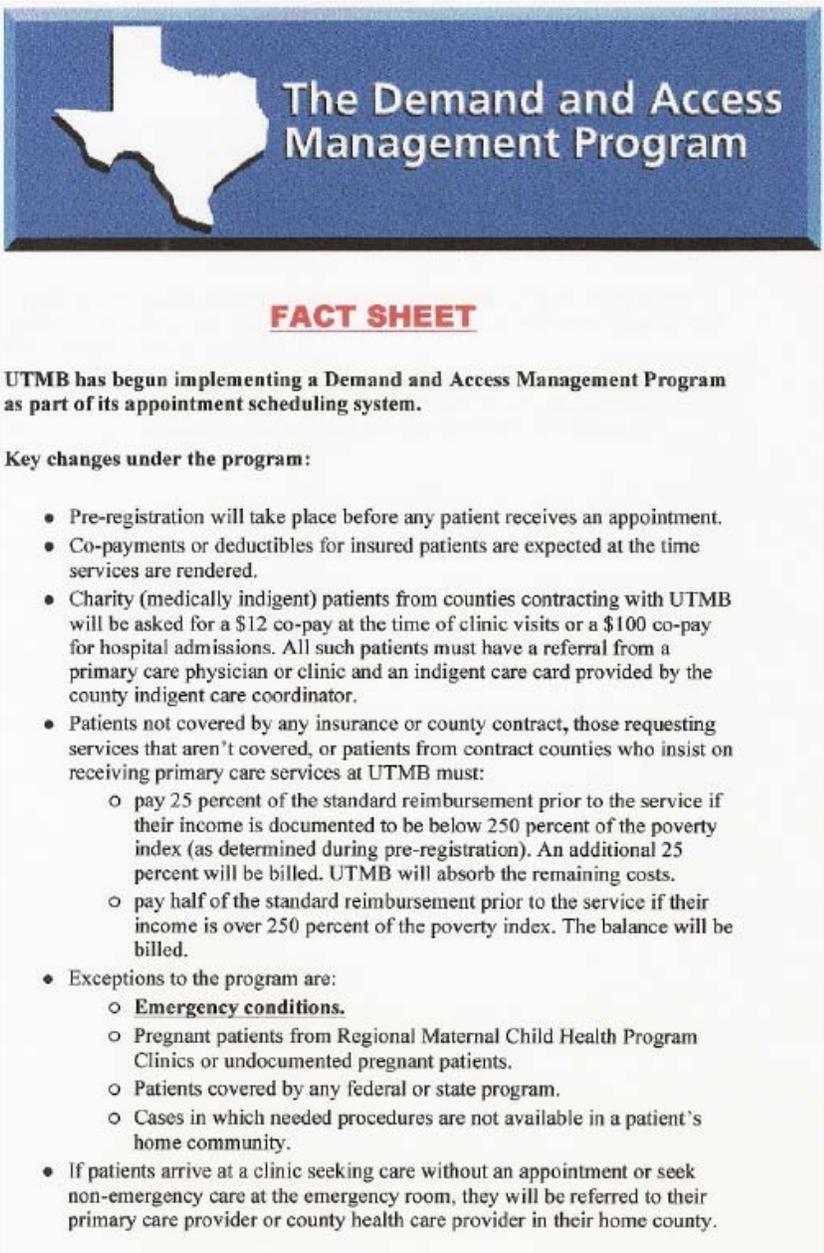
⁹² 2006 University of Texas Medical Branch Annual Survey of Hospitals, Section E, item 5b, page 15.

⁹³ 2007 University of Texas Medical Branch Annual Survey of Hospitals, Section D, item 5b, page 17.

⁹⁴ *Emergency Medical Treatment and Labor Act*. 42 USC § 1395dd.

Since there was no charity care or financial assistance policy available to the public during the survey period or on the UTMB website and there are policies directed at poor patients that require payments, it is unclear how the term “charity care” is being used by UTMB in the Annual Survey of Hospitals. One reference to the term “charity care” was used by UTMB to refer to certain patients in the “Fact Sheet on the Demand and Access Management Program.”⁹⁵

(Figure 15) According to the fact sheet, patients designated as charity patients are from counties contracting with UTMB. This raises at least two questions about who is included by UTMB in the reporting of charity care. The first question is whether charity patients reported on the Annual Hospital Survey receive services free of charge and the second is whether patients funded by county contracts are designated as charity patients. In a 2006 presentation to the Texas Senate Finance Committee regarding information on the Texas Annual Hospital Surveys, it was unknown whether the County Indigent Health Care Program funds had “already been accounted for in *reducing* the amount of uncompensated care” in the surveys.⁹⁶ (Emphasis added.)



The graphic is a fact sheet titled "The Demand and Access Management Program" with a white outline of Texas on a blue background. Below the title, the text reads: "FACT SHEET", "UTMB has begun implementing a Demand and Access Management Program as part of its appointment scheduling system.", and "Key changes under the program:". The key changes are listed in bullet points.

The Demand and Access Management Program

FACT SHEET

UTMB has begun implementing a Demand and Access Management Program as part of its appointment scheduling system.

Key changes under the program:

- Pre-registration will take place before any patient receives an appointment.
- Co-payments or deductibles for insured patients are expected at the time services are rendered.
- Charity (medically indigent) patients from counties contracting with UTMB will be asked for a \$12 co-pay at the time of clinic visits or a \$100 co-pay for hospital admissions. All such patients must have a referral from a primary care physician or clinic and an indigent care card provided by the county indigent care coordinator.
- Patients not covered by any insurance or county contract, those requesting services that aren't covered, or patients from contract counties who insist on receiving primary care services at UTMB must:
 - pay 25 percent of the standard reimbursement prior to the service if their income is documented to be below 250 percent of the poverty index (as determined during pre-registration). An additional 25 percent will be billed. UTMB will absorb the remaining costs.
 - pay half of the standard reimbursement prior to the service if their income is over 250 percent of the poverty index. The balance will be billed.
- Exceptions to the program are:
 - **Emergency conditions.**
 - Pregnant patients from Regional Maternal Child Health Program Clinics or undocumented pregnant patients.
 - Patients covered by any federal or state program.
 - Cases in which needed procedures are not available in a patient's home community.
- If patients arrive at a clinic seeking care without an appointment or seek non-emergency care at the emergency room, they will be referred to their primary care provider or county health care provider in their home county.

⁹⁵ University of Texas Medical Branch, *The Demand and Access Management Program Fact Sheet*.

⁹⁶ Uncompensated Care in Texas Working Group, *Uncompensated Care and Medicaid Hospital Reimbursement* (2006 [cited September 2 2009]); available from <http://www.hhsc.state.tx.us/news/present79.asp>.

However, in 2009 the Uncompensated Care in Texas Work Group recommended that these local funds be reported as sources of payment.⁹⁷

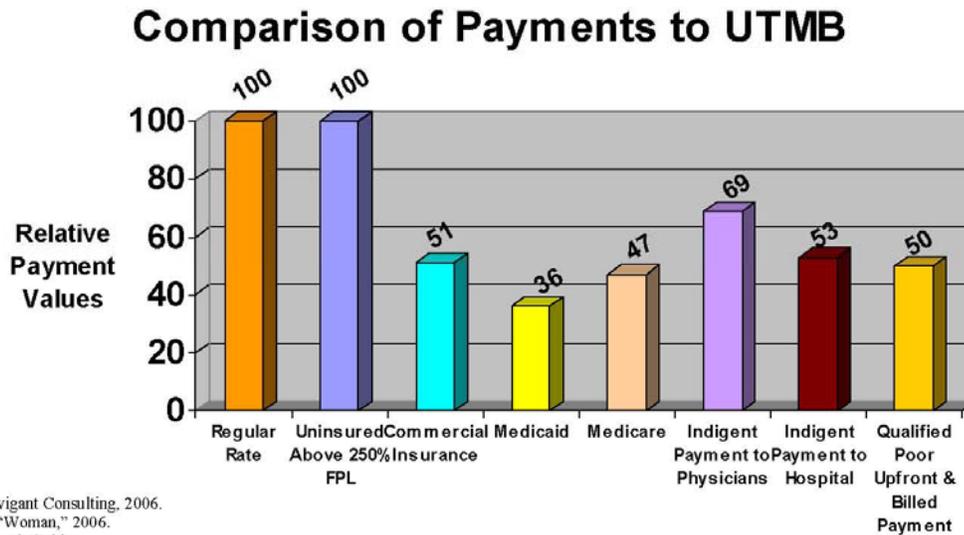


Figure 16

In fact, the level of payment provided to UTMB hospitals and physicians for “indigent services” including cash collections and county contracts, was substantial in comparison to the level of payment for the same services when provided to patients with health insurance coverage through Medicare. Information on the payments made for indigent care was gathered by the Navigant Consulting Group in its 2006 report. The Navigant Consulting Group was hired at a cost of \$1.75 million to make detailed recommendations for UTMB on opportunities for financial, operational and quality improvement.⁹⁸ According to Navigant, UTMB physicians received payments for services to indigent patients in 2006 at a rate that was 147 percent of the Medicare rate. The hospital received payments at a rate that was 113 percent of the Medicare rate.^{99,100} (Figure 16) These payments are allocated internally in order to establish an indigent care pool that has become the second highest payer for UTMB physicians.¹⁰¹ In other words, internally allocated funds reimburse UTMB physicians at a higher rate than most other payers. Also, according to Navigant, the revenue supporting “unsponsored” care comes close to meeting the expenses for unsponsored care, even at these high payment rates.¹⁰² As a result, unsponsored care is almost entirely funded through several funding mechanisms. (Figure 17)

⁹⁷ Uncompensated Care in Texas Working Group, *Uncompensated Care in Texas: Moving toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs* (2009 [cited August 6 2009]); available from <http://www.hhsc.state.tx.us/news/present80.asp>.

⁹⁸ Marty Schladen, "Conflict Allegations Don't Hold Up," *Galveston County Daily News*, July 8 2006.

⁹⁹ In an email from Nathan Andersen, UTMB Interim Public Information Officer, to the author on September 3, 2009, the Navigant Consulting Report is public information and is not confidential.

¹⁰⁰ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," (UTMB, 2006), Book IV-Section VI-page 5.

¹⁰¹ *Ibid.*, Book IV-Section VI-page 13.

¹⁰² *Ibid.*, Book IV-Section VI-page 4.

The deficit on unsponsored care in 2006 was \$40,000, according to Navigant Consulting.¹⁰³ At the same time, the cost-cutting measures and layoffs in late 2006 were reported to be necessary by Dr. Stobo in order to continue the medical branch’s mission of providing indigent care while facing a reported \$118 million in uncompensated or charity care spending.¹⁰⁴ The Texas Legislature is aware that the reporting of uncompensated care is in need of changes that make such reporting “reliable, transparent and can provide policymakers with information they require to shape policy that effectively addresses uncompensated care.”¹⁰⁵ The changes to uncompensated care reporting that have been recommended by the Senate Bill 10 Work Group on Hospital Uncompensated Care are similar to the steps taken by Navigant Consulting in their 2006 report. The Work Group proposes a new term called “residual unreimbursed uncompensated care” that will provide consistency and coherence in understanding the actual costs of treating uninsured and underinsured Texans.¹⁰⁶ The Navigant Consulting report shows the deficit on unsponsored care for 2006 was \$40,000 and, in some respects, this is analogous to residual unreimbursed uncompensated care that the legislative Work Group is proposing for shaping policy.¹⁰⁷

**UTMB HOSPITALS AND CLINICS
UNSPONSORED CARE REVENUES AND
EXPENSES (IN MILLIONS)**

Revenues Allocated to Support Unsponsored Care:	Budget FY 2006
General Revenue Appropriations	\$ 91.40
Indigent Care Fund	10.00
Tertiary Care Fund	0.94
County Contracts	7.45
MHMR	1.63
Cash Payments	7.55
Total Revenues	\$ 118.96
Unsponsored Care Expenses:	
Hospital Expense	88.2
Practice Plan Expense	30.8
Total Expenses	\$ 119.0
Margin (deficit) on Unsponsored Care	\$ (0.04)

In order to put the cost of health care services at UTMB in perspective, it is helpful to know what UTMB officials have stated regarding billing for health care services. In 2006, a Galveston Daily News article detailing responses to news reports about people without health insurance being billed at a much higher rate than those with insurance, Dr. Stobo, then president of UTMB, stated that no one actually pays the regular rate. According to Stobo, “Less than 1 percent of the people

Source: Navigant, 2006, Book IV, Section VI, page 4

Figure 17

¹⁰³ Ibid.

¹⁰⁴ Laura Elder, "Medical School in Critical Condition," *Galveston County Daily News*, December 31 2006.

¹⁰⁵ Texas Health and Human Services Commission, *Uncompensated Care in Texas: Moving toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs*.

¹⁰⁶ Ibid.

¹⁰⁷ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Book IV-Section VI-page 4.

who don't have health insurance actually pay that charge."¹⁰⁸ In that article, the chief financial officer of UTMB hospitals and clinics stated that the uninsured are billed at the higher rate but, as a group, end up paying about 10 percent of what they are billed and that this amount is "written off." There remains conflicting information on the amount of charges billed to the uninsured based on the UTMB Deposit Guide as compared to statements made by the chief financial officer. However, the amount charged to people with commercial insurance averaged 51% of the regular rate and the amount of charges billed to uninsured people with incomes above 250% of the federal poverty level was at the regular rate, according to the chief financial officer in 2006.¹⁰⁹ Navigant Consulting recommended that UTMB develop a formal self-pay discount policy.¹¹⁰

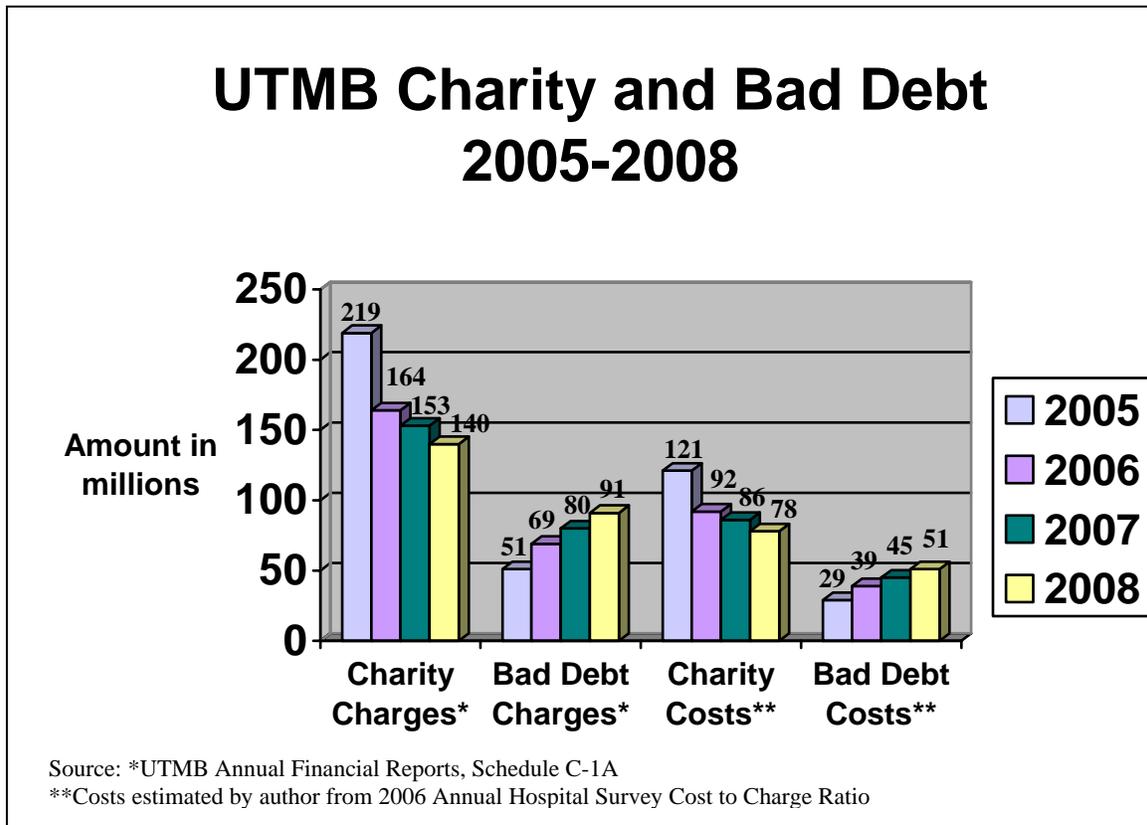


Figure 18

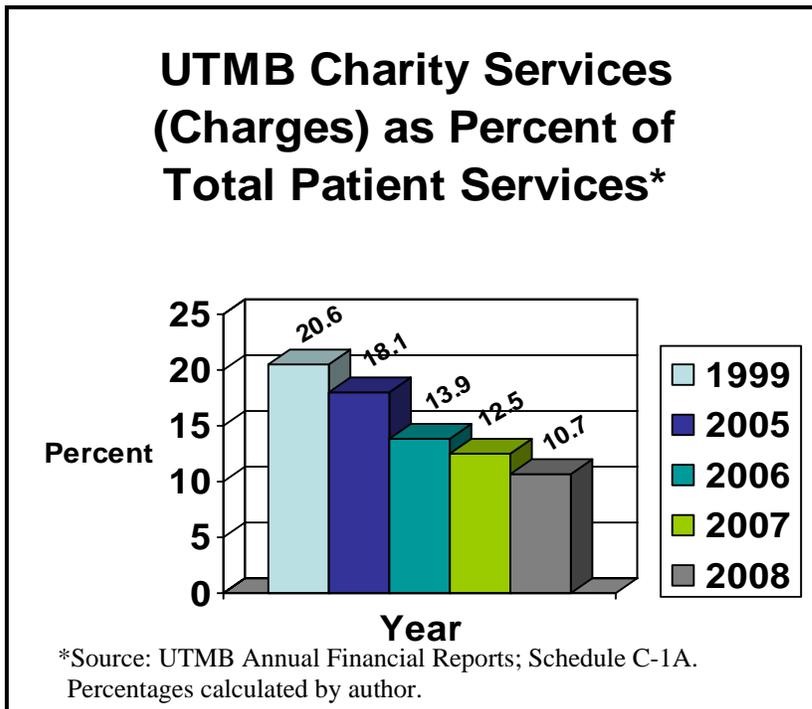
It is unclear whether the statements by UTMB officials meant that these uninsured patients had services that resulted in bad debt or whether any of the people needing care were told about charity care policies. However, data from 2005 to 2008 show that the amount of services designated as charity care have declined by 36% and the amount of services designated as bad debt have increased by 44%. (Figure 18)

¹⁰⁸ Hawes, "Woman: No One Looking out for Middle Class."

¹⁰⁹ Ibid.

¹¹⁰ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Executive Summary-Page 88.

This trend of increases in medical debt can have devastating consequences for patients, which are compounded by our nation's economic downturn. For example, the proportion of working-age Americans who struggled to pay medical bills and accumulated medical debt climbed from 34 percent to 41 percent—or 72 million people—between 2005 and 2007, according to a 2008 Commonwealth Fund report. Families with low or moderate incomes have been particularly hard hit, as have adults who have gaps in health coverage or those people who are underinsured. Medical bills or the accumulation of medical debt contributed to an estimated 28 million adults using up all their savings, 21 million incurring large credit card debt, and another 21 million becoming unable to pay for basic necessities.¹¹¹ Many Americans have recently lost jobs due to the global financial crisis resulting in a greater chance of debt burden. Medical debts can further exacerbate this problem, especially if the debt results in a lower credit rating, making it more difficult and costly to rent property, obtain utility services, and receive new credit.¹¹² Even before the financial crisis took hold, the number of Americans filing for bankruptcy due to medical debt was rising. In 2007 over 62% of bankruptcy filers had a medical debt-related reason for filing.¹¹³



The increase in bad debt and decline in reported charity services has been even greater over time. According to UTMB Annual Financial Reports, the amount of charity services as a percentage of gross patient services reported from 1999 to 2008 has declined by about one-half, from 20.6 percent to 10.7 percent. (Figure 19)

Another aspect of financial screening credited to DAMP rules

Figure 19

¹¹¹ Michelle Doty et al., *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families* (The Commonwealth Fund, 2008 [cited September 2 2009]); available from <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2008/Aug/Seeing-Red--The-Growing-Burden-of-Medical-Bills-and-Debt-Faced-by-U-S--Families.aspx>.

¹¹² Kathy Chu, *Recession Takes Toll on Americans' Credit Scores* (May 27 2009 [cited September 2 2009]); available from <http://libux.utmb.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=J0E017794219409&loginpage=Login.asp&site=ehost-live>

¹¹³ David Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *American Journal of Medicine* 122, no. 8 (2009).

is that patients can not schedule an appointment with a doctor if they owe for previous treatment, except in certain circumstances. Called “bad-debt flags,” some patients who were treated at UTMB can not return for additional follow-up care unless payments are agreed to. With no publicly available written charity care or financial assistance policies and charges to the uninsured that are similar to those with private insurance, in 2003 the Wall Street Journal reported that “a staggering 64,000 people, or 7% of those in the hospital’s records” are subject to bad debt flags.¹¹⁴ The Healthcare Financial Management Association recommends following Generally Accepted Accounting Principles (GAAP) in the recording of bad debt, including the requirement that bad debt is recorded only when collectibility is reasonably assured. The Healthcare Financial Management Association also states that the provider’s charity care policy should address instances in which patients do not provide sufficient information to make a determination of eligibility for charity care and that providers should have policies that recognize situations of unexpected financial hardship after service is rendered.¹¹⁵

The DAMP program changed over time, eventually including not only the imposition of fees, but also, “hard blocks,” to prevent follow-up appointments after emergency room visits.¹¹⁶ The DAMP office changes have been outlined in the Navigant report through 2006.¹¹⁷ (Figure 20) Several of the DAMP processes fall broadly under “bureaucratic barriers.” For example, patients are financially screened at a location off-campus and are blocked from follow-up appointments unless an additional financial counseling visit occurs. Complicating the enrollment process has been to shown to significantly limit access to programs such as the State Children’s Health Insurance Program.^{118,119}

¹¹⁴Wysocki, "The Rules: At One Hospital, a Stark Solution for Allocating Care."

¹¹⁵ Healthcare Financial Management, *Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers* (2006 [cited September 29 2009]); available from http://www.hfma.org/library/accounting/reporting/ppb_charity_bad_debt.htm.

¹¹⁶ Harvey Rice, "UTMB Cutting Indigent-Care Program Funds : A \$59 Million Shortfall Spurred Slash in Budget," *Houston Chronicle*, September 6 2008.

¹¹⁷ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Book IV-Section VI-page 8.

¹¹⁸ John Hoadley, Peter Cunningham, and Megan McHugh, "Popular Medicaid Programs Do Battle with State Budget Pressures: Perspectives from Twelve States," *Health Affairs* 23, no. 2 (2004).

¹¹⁹ Susan Rushing and Myron Genel, "Our Porous Safety Net for Children," *Archives of Pediatric & Adolescent Medicine* 159, no. 11 (2005).

Demand and Access Management Program (DAMP)

UTMB Hospital and Clinics and the Faculty Group Practice initiated DAMP-4 in September 2005, building upon prior initiative, to control utilization and costs.

DAMP-1 included imposition of co-payment and pre-payment and enrollment in county programs to increase the proportion of indigent persons with sponsorship.

DAMP-2 imposed radiology pre-certification; management of delinquent accounts; cash collection on day of procedures for diagnostic tests; and financial verification before surgery.

DAMP-3 centralized the financial screening function off-campus as well as tracking of episodes of care; the establishment of outpatient targets for each clinic; the involvement of area medical directors in monitoring the utilization.

DAMP-4 instituted 'hard blocks' to prevent follow-up appointments from the emergency department without a return to Financial Counseling; further defined the management of episodes of care, including a visit authorization process, also managed by area medical directors.

Source: Navigant, 2006, Book IV, Section VI, page 8

Figure 20

The Navigant report credits the DAMP office with “successfully plac[ing] controls on access for new patients except in the Emergency Department.”¹²⁰ Even after patients have been financially screened and have made an appointment, unless the patient is a child, “anyone who shows up at UTMB without the money is sent home.”¹²¹ In addition to financial screening, upfront payments, and bureaucratic barriers, the DAMP office is associated with departmental caps for uninsured patients. According to one UTMB physician, these caps consist of departmental quotas on indigent patients.¹²²

In the United States, requiring upfront payments and turning away patients who *qualify for discounts* if those payments are not received does not appear to be common. As an example, the Internal Revenue Service surveyed 487 hospitals in 2007. Eighty-five percent of the responding hospitals did not require payment prior to providing inpatient, outpatient, or emergency room services.¹²³ In another survey of hospitals and health centers in five cities, most providers said they had not denied services to people who failed to comply with payment rules, or that such cases were extremely rare.¹²⁴

Concerning the level of payments required at UTMB for services to uninsured patients through the DAMP office, in comparison to five public hospitals surveyed in

¹²⁰ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Book IV-Section VI-page 13.

¹²¹ Wysocki, "The Rules: At One Hospital, a Stark Solution for Allocating Care."

¹²² del Bosque, "Storm over UTMB: What Happened to the Heart of Texas Health Care?."

¹²³ Internal Revenue Service, "Hospital Compliance Project : Interim Report," (2007).

¹²⁴ Susan Felt-Lisk, Megan McHugh, and Embry Howell, "Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?," *Health Affairs* 21, no. 5 (2002).

2004, the level of payment at UTMB is higher. In addition, at least one of the hospitals surveyed specifically reported that services are not denied for inability to pay. These five programs for the uninsured included access to a comprehensive set of services, unlike the process described through the DAMP office.¹²⁵ (Figure 21)

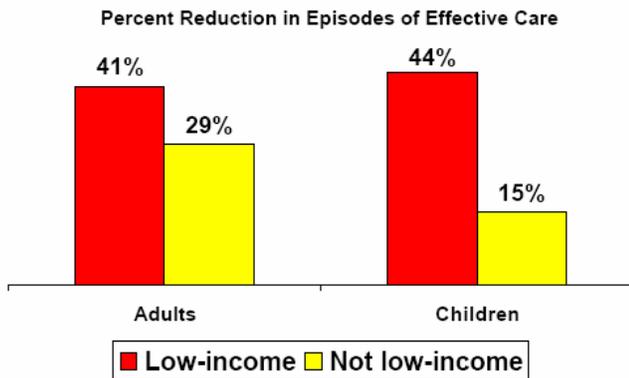
The National Association of Public Hospitals and Health Systems Survey: Managing Care for Uninsured Patients

	Boston Care Net	Indianapolis Health Advantage	Miami TrustCare	Dallas Parkland Healthplus	Richmond VCC
Income Eligibility (FPL)	200%	200%	150%	200%	200%
Enrollment, 2004	22,000	48,000	2,000	84,000	16,000
Services Covered: Primary, Inpatient, Specialty	Yes	Yes	Yes	Yes	Yes
Cost Sharing:					
Primary Care	No	\$10	No	\$10	\$5
Inpatient	No	No	No	\$30	No
Outpatient	No	\$50	No	\$ 2	No
Specialty	No	\$30	No	\$25	\$10

Source: NAPH Managing Care for Uninsured Patients 2005. Cited in Navigant, 2006, Book IV, Section VI, page 17
Figure 21

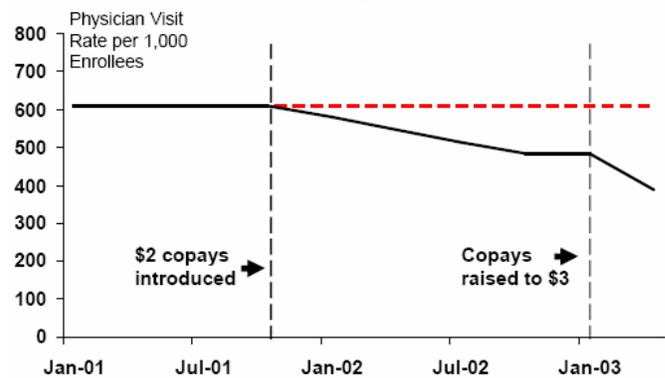
Cost sharing, such as copayments, has been shown to reduce necessary care with a greater harmful effect among poor people.¹²⁶ (Figure 22) Copayments in the Medicaid program dramatically reduce seeking health care even at nominal levels.¹²⁷ (Figure 23)

Low-income Patients More Vulnerable to Copayments



Source: J. Newhouse, *Free for All*, 1996 (RAND Health Ins. Expt)
Figure 22

\$2 & \$3 Copays Affected Physician Visits in Utah Medicaid



Source: Ku, Deschamps and Hilman, CBPP 2004
Figure 23

Of particular concern for Galveston County residents is what impact the DAMP procedures have had on people living within the county. Since no charity care policies or

¹²⁵ National Association of Public Hospitals and Health Systems, "Managing Care for Uninsured Patients: Five Success Stories from America's Public Hospitals and Health Systems," (Washington, D.C.: 2005).

¹²⁶ Newhouse, *Free for All? : Lessons from the Rand Health Insurance Experiment*.

¹²⁷ Ku, Deschamps, and Hilman, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program."

financial assistance policies were available during the survey period or on the UTMB website, it is unknown whether the health care needs of Galveston County residents are taken into consideration when enforcing DAMP procedures. The Galveston County Health District, through the 4Cs clinics, provides primary health care to qualified Galveston County residents. In one quarter of 2007, 817 patients were referred for specialty care through the DAMP office and 23% were accepted.¹²⁸ Outcome data for 131 referrals primarily during 2007 through DAMP by health care providers at St. Vincent's House Clinics, an Episcopal mission in the city of Galveston offering free primary care, showed that only 19% were offered an appointment with a specialty clinic.¹²⁹ To put this another way, 77-81% of Galveston County residents whose providers determined that specialty care was needed, did not receive such care when referrals were processed through the DAMP office. (Figure 24)

Some of the explanation as to how the majority of patients residing in Galveston County are not seen for referral services through the DAMP office relates to a third tier of the DAMP process, described here as "referral judgments." This term does not include the relatively unusual case of making a decision about expensive or unusual therapies such as cochlear implants or medications needed after heart transplants.^{130,131} Rather, the term refers to the process through which all or most referrals must go through at UTMB. For example, according to Navigant Consulting, the DAMP office excluded 43% of requested visits in the first seven months of 1996, or 4,423 people out of 10,286 were excluded.¹³² County of residency was not included in these numbers. In the initial phases of the DAMP office process, people referred for care were screened first by financial screeners, however financial screening was only part of this initial process.¹³³ Financial screeners also visually scrutinized potential patients, staying "on the lookout for people who falsely claim to be indigent. 'They come in with diamonds and wearing Saks Fifth'."¹³⁴

At some point, perhaps as part of "DAMP-3" as characterized by Navigant Consulting, area medical directors became involved in monitoring utilization through the DAMP office. Since there is no other publicly available information on the DAMP process, it is unclear whether financial screeners continue to visually scrutinize potential patients. However, the involvement of area medical directors has been discussed. For example, in August of 2008, the interim Chief Operating Officer at UTMB stated that the decision about whether to take on a patient is clinically based. The officer stated, "We log

¹²⁸ del Bosque, "Storm over UTMB: What Happened to the Heart of Texas Health Care?."

¹²⁹ Amy Doss, "Damp Revamp: St. Vincent's Clinic Damp Referral Evaluation," (Galveston: University of Texas Medical Branch, 2007).

¹³⁰ Wysocki, "The Rules: At One Hospital, a Stark Solution for Allocating Care."

¹³¹ Frank Koller, *Galveston, Oh Galveston: Rationing Health Care in Texas* (CBC Radio, December 8, 2003 [cited September 1 2009]); available from http://www.cbc.ca/news/background/galveston_healthcare/.

¹³² Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Book IV-Section VI-page 9.

¹³³ Koller, *Galveston, Oh Galveston: Rationing Health Care in Texas*.

¹³⁴ Wysocki, "The Rules: At One Hospital, a Stark Solution for Allocating Care."

consults and pass that log onto the physicians who determine whether they can or need to see the patient based on clinical data and allocation.”¹³⁵

The role of medical directors in determining whether uninsured patients are seen is not based on face-to-face encounters. Rather, the determinations are based on paper referrals. According to a 2009 report of the process, “Stacks of referrals would stream in from other health care providers, UTMB clinics, and rural counties.”¹³⁶ The role of medical directors at UTMB in the DAMP process is analogous to the role of medical directors in health plans in that a direct care physician or health care provider has already determined that a medically necessary service is needed and the medical director then makes a judgment as to whether that service will be offered.¹³⁷

¹³⁵ Molpus, Mackenzie, and Commins, *Help the Uninsured (without Going Broke)*.

¹³⁶ del Bosque, "Storm over UTMB: What Happened to the Heart of Texas Health Care?."

¹³⁷ American Medical Association Council on Ethical and Judicial Affairs, *Ethical Obligations of Medical Directors* (American Medical Association, 1999 [cited September 29 2009]); available from http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_3a99.pdf.

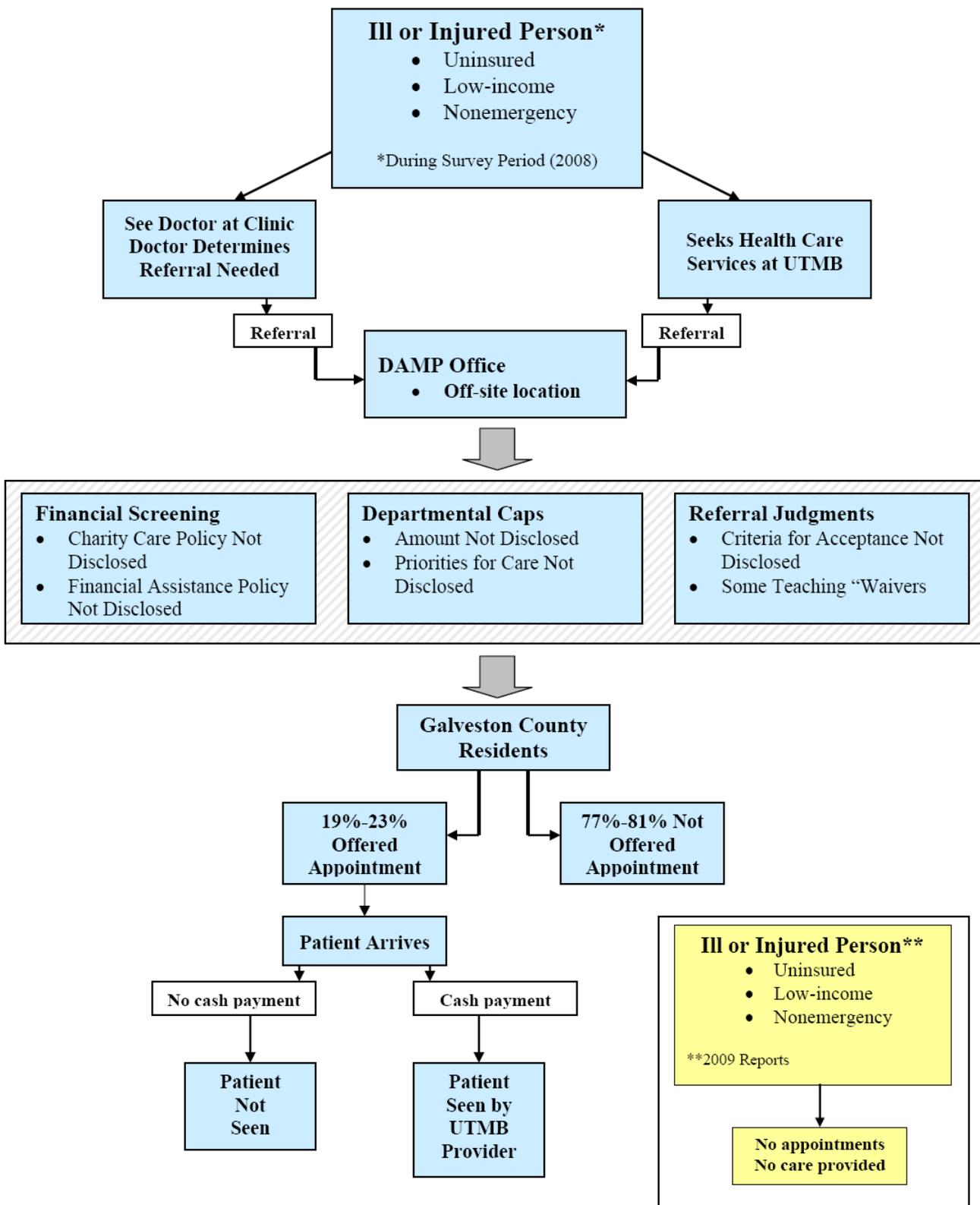


Figure 24

According to information provided by Dr. Stobo for 2006, about half of uninsured patients were turned away from UTMB.¹³⁸ Navigant Consulting reported that 43% of eligible patients were excluded from health care services for the first seven months of 2006. Navigant Consulting stated that these excluded patients were “Priority 3.”¹³⁹ However, there is no publicly available information on what the priorities are or how these priorities are determined. In other words, it remains entirely unknown on what basis 4,423 patients were excluded from health care services at UTMB in the first seven months of 2006 while 5,863 patients were accepted for appointments. There are two factors which have been mentioned though not fully delineated as to priority-setting: 1) reducing access for uninsured patients to decrease uncompensated care costs and 2) teaching or educational considerations.^{140,141,142}

Navigant Consulting recognized that, in regard to managing unsponsored patients, “Guiding principles and a compelling vision are not apparent.” Their report suggests the following questions could serve to focus such principles:¹⁴³ (Figure 25)

- Improved access to health care?
- Delivery of services in appropriate settings?
- Change health-seeking behaviors?
- Protect financial health of UTMB?
- Establish a leadership position in respect to health policy and research?

Figure 25

As the Navigant Consulting report suggests, one of the reasons to have clearly identified goals for the DAMP process is to be able to evaluate whether the process is fulfilling its purpose or purposes. UTMB, and others, have referred to the DAMP process as “rationing,” though some physicians reserve the term “rationing” for cases in which there is a scarcity of resources, as in the case of organ transplants.¹⁴⁴ Strictly speaking, then, the DAMP process is a process of allocation of funds.

As outlined by Navigant Consulting for 2006, of the \$118.96 million allocated for unsponsored care, \$111.41 million was public funding and \$7.55 million was derived from patients’ cash payments.¹⁴⁵ There is general agreement that the allocation of public funds should be made through a transparent, public process that is accountable to the public, particularly the local community.

¹³⁸ Rice, "UTMB Cutting Indigent-Care Program Funds : A \$59 Million Shortfall Spurred Slash in Budget."

¹³⁹ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Book IV-Section VI-page 9.

¹⁴⁰ Stobo, *A Message from President John D. Stobo: The Demand and Access Management Program*.

¹⁴¹ The University of Texas System, *Serving the Uninsured* (University of Texas System, 2005 [cited September 29 2009]); available from <http://www.utsystem.edu/news/features/uncompensatedcare-032305.htm>.

¹⁴² Wysocki, "The Rules: At One Hospital, a Stark Solution for Allocating Care."

¹⁴³ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Book IV-Section VI-page 15.

¹⁴⁴ Daniel P. Sulmasy, "Cancer Care, Money, and the Value of Life: Whose Justice? Which Rationality?," *Journal of Clinical Oncology* 25, no. 2 (2007).

¹⁴⁵ Navigant Consulting, "UTMB Healthcare Systems, Confidential Draft," Book IV-Section VI-page 4.

Priority setting in health care is of deep concern to many Americans and to congressional leaders.¹⁴⁶ The *process* of deciding who receives care and who is excluded is often considered to be as important as the criteria developed for decision making.¹⁴⁷ Patients, health care providers, and the public can come to believe that decisions are guided solely by financial considerations instead of the welfare of the patient when the criteria and process are not publicly known.¹⁴⁸ Further, even fair minded practitioners can have difficulty isolating medical judgments from social or other factors.¹⁴⁹ No one doubts that there are limitations on financial resources, so that not only who decides, but how decisions are made, becomes of paramount importance. A process for decisions that involves excluding some patients has been described as follows: "Key elements of fair process will involve transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; and procedures for revising decisions in light of challenges to them."¹⁵⁰

Most of the discussion surrounding the fair process of priority setting and the allocation of funds, revolves around unusual cases such as expensive or new technologies, which is not the case for the thousands of people excluded from health care at UTMB through the DAMP office. There are few examples of priority setting in health care that have involved public funds and limiting access to health care. One example is in Oregon. Even though in Oregon there were many contentious issues, the public was actively solicited in a community meeting process to guide the allocation decisions.¹⁵¹ The basis for decision making in hospitals for the care of uninsured patients has revolved around *consistency* in applying eligibility criteria. Consistency in patient care practices is also a standard according to the Joint Commission for Accreditation of Health Care Organizations.¹⁵²

A related concept is that a health policy, such as DAMP, should be accountable for health.¹⁵³ In Galveston County, soon after the DAMP process was initiated, the 4Cs Federally Qualified Health Care Center's Medical Director noted that "Our largest challenge is managing and treating the huge inflow of patients caused by the Demand and Access Management Program implemented last year by UTMB."¹⁵⁴ During the UTMB

¹⁴⁶ Larry R. Churchill, *Rationing Health Care in America : Perceptions and Principles of Justice* (Notre Dame, Ind.: University of Notre Dame Press, 1987), 122-25.

¹⁴⁷ Laura J. McGough et al., "Which Patients First? Setting Priorities for Antiretroviral Therapy Where Resources Are Limited," *American Journal of Public Health* 95, no. 7 (2005).

¹⁴⁸ Norman Daniels, "Accountability for Reasonableness," *British Medical Journal* 321, no. 7272 (2000).

¹⁴⁹ McGough et al., "Which Patients First? Setting Priorities for Antiretroviral Therapy Where Resources Are Limited."

¹⁵⁰ Daniels, "Accountability for Reasonableness," 1300.

¹⁵¹ Michael J. Garland and Romana Hasnain, "Health Care in Common: Setting Priorities in Oregon," *Hastings Center Report* 20, no. 5 (1990).

¹⁵² Steven D. Pearson, James E. Sabin, and Ezekiel J. Emanuel, *No Margin, No Mission : Health-Care Organizations and the Quest for Ethical Excellence* (Oxford ; New York: Oxford University Press, 2003), 28.

¹⁵³ J. Frank Wharam and Norman Daniels, "Toward Evidence-Based Policy Making and Standardized Assessment of Health Policy Reform," *Journal of the American Medical Association* 298, no. 6 (2007).

¹⁵⁴ Joanna Charles Bremer, "Pfizer Program Provides Pharmaceuticals to Needy Patients," *Impact* 24, no. 6 (2000).

survey process, none of the monitors received information on free or reduced cost care policies, though several monitors were told to go to the 4Cs clinics. In 2009 the 4Cs clinics employed four physicians and six mid-level practitioners providing health care services, whereas UTMB employed 823 faculty involved in patient care services in October of 2008.^{155,156} In a May 2009 email regarding indigent care services, the Interim Executive Vice President and Chief Executive Officer of UTMB Health System stated that “Galveston County residents will be able to receive care at the Four Cs Clinic and St. Vincent’s Clinic.”¹⁵⁷ According to the National Association of Public Hospitals and Health Systems, public hospitals are committed to the provision of outpatient care to uninsured patients, low-income individuals and the chronically ill. Public hospitals are also leaders in providing primary care in outpatient settings, often serving as medical homes to residents in their communities.¹⁵⁸ An Institute of Medicine report has noted that providers of health care services to uninsured and low-income patients, such as public hospitals and Federally Qualified Health Care Centers, are highly interdependent.¹⁵⁹ When only uninsured patients are referred for primary health care services by a public hospital to a community health center, problems with funding are merely shifted.¹⁶⁰ In addition, access to specialty services is considered a necessary component of high quality health care.¹⁶¹ Lack of access to specialty services through the DAMP office was reported for 77% of Galveston County community health center patients in one quarter of 2007.¹⁶²

The surveys, site visits, and further research has shown that access to health care services for Galveston County residents, particularly for uninsured, underinsured, and low-income residents is difficult due to the following: (Figure 26)

¹⁵⁵ Galveston County Health District, *4Cs Clinic Providers* (2009 [cited September 29 2009]); available from <http://www.gchd.org/4cs/staff.htm>.

¹⁵⁶ UTMB Office of Institutional Effectiveness, *Faculty Summary Fall 2008* (2009 [cited September 29 2009]); available from <http://www.utmb.edu/facts/downloads/faculty/pdf/files/FacultySummary-Fall2008.pdf>.

¹⁵⁷ Karen Sexton, May 1, 2009.

¹⁵⁸ Obaid S. Zaman, Linda C. Cummings, and Sari Siegel Spieler, *America's Public Hospitals and Health Systems, 2007* (2009); available from <http://www.naph.org/sp/Search.aspx?SearchMode=1&SearchPhrase=america's+public+hospitals+and+health+systems+2007>.

¹⁵⁹ Marion Ein Lewin and Altman Stuart, "America's Health Care Safety Net: Intact but Endangered," (Washington, DC: Institute of Medicine, 2000), 24.

¹⁶⁰ Laurie E. Felland, Robert E. Hurley, and Nicole M. Kemper, *Safety Net Hospital Emergency Departments: Creating Safety Valves for Non-Urgent Care* (Center for Studying Health System Change, May 2008 [cited September 1 2009]); available from <http://www.hschange.com/CONTENT/983/>.

¹⁶¹ Joel S. Weissman et al., "Limits to the Safety Net: Teaching Hospital Faculty Report on Their Patients' Access to Care," *Health Affairs* 22, no. 6 (2003).

¹⁶² del Bosque, "Storm over UTMB: What Happened to the Heart of Texas Health Care?."

- No publicly available policies on charity care or financial assistance
- High levels of copayments for uninsured patients
- Services billed to uninsured and underinsured patients at levels similar to those with private insurance
- Denials of care for eligible patients who arrive at appointments without cash
- “Hard-blocks” on follow-up care for emergency department patients
- Visual scrutiny of patients in order to determine exclusions from health care services
- Bureaucratic barriers such as off-site location of the DAMP office
- “Bad debt flags” on hospital computers that prevent patients from making appointments
- Priority setting that is not publicly available
- Lack of development of written policies on eligibility through the DAMP office for health care providers, patients, and the DAMP personnel
- Lack of publicly available reports on sources of funding for internally allocated unsponsored care funds

Figure 26

Since there are no publicly available charity care or financial assistance policies, information available remains primarily through news reports. Concerning the policy approach to the care of uninsured patients, a 2009 report in the Texas Observer detailed the practice of turning away all uninsured patients by UTMB. This is of particularly grave concern for Galveston County residents. Administrative staff of the DAMP office were given a telephone script for responding to uninsured patients. According to the Texas Observer, if an uninsured patient pleaded to administrative staff “If you do not take me I will die,” or “You are trying to kill me,” then the response should be “I hear you and I know that you are frustrated. The UTMB health system is currently caring for as many unsponsored patients as we can. Unfortunately, we have exhausted the funding available for unsponsored care and are unable to accept any more new patient referrals at this time. I encourage you to call your PCP/referring physician or your local county office for help with your immediate health care needs.”¹⁶³

Regarding funding available for uninsured patients, lack of public disclosure means that available funding amounts and sources are not known. Hindering understanding of information that is available is the variation and inconsistency in the terms that are used to discuss uninsured patients and their care. For example, if only the term “uncompensated care” is used, charity care could decline to zero and the total amount could be comprised only of bad debt. Another source of confusion is that “indigent health care” and “unsponsored health care” can both be categories of specific patients and sources of funding. For example, “indigent health care” could refer to funds received through County Indigent Health Care sources or unclaimed lottery funds designated for indigent health care.¹⁶⁴

¹⁶³ Ibid.

¹⁶⁴ Caton Fenz, "Providing Helath Care to the Uninsured in Texas: A Guide for County Officials," (2000).

There are several aspects of the provision of charity care that have been emphasized in the work of consumer groups as well as federal and state regulations. Two of these are whether eligibility for charity services and discounted services are applied consistently and whether the services provided are responsive to community needs. Some organizations, such as the World Health Organization, have fostered the special obligation medical schools, such as UTMB, have to “direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have the mandate to serve. The priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals, and the public.”¹⁶⁵

Summary of Findings and Recommendations for The University of Texas Medical Branch

Findings:

Results of Surveys and Site Visits

- In thirty-eight of thirty-nine phone calls and site visits, monitors were told that no free care was available and no written policies on free or reduced cost care were provided. In one phone call to the hospital main number, the monitor was told that free care is available and the call was immediately transferred to the Demand and Access Management Program (DAMP) office. During one phone call, a community monitor was told that discounted care is available based on federal poverty guidelines, though the policy was not allowed to be shared with the public.
- No signs were posted regarding the availability of written policies on free or reduced cost care at any of the hospital or clinic sites.
- In twenty-six of the thirty-nine phone calls and site visits, monitors spoke to or were referred to personnel in the DAMP office. DAMP office personnel often did not know whether UTMB provides any free care or responded that there is no free care at UTMB. Several monitors were told that discounted care is available but that there is no written policy regarding financial assistance. During several surveys, monitors were told to “go to your county,” even though all of the monitors were Galveston County residents, or monitors were told to go to 4Cs clinic.

¹⁶⁵ Robert F. Woollard, "Caring for a Common Future: Medical Schools' Social Accountability," *Medical Education* 40, no. 4 (2006).

- Decisions about who is accepted for possible discounted care, according to a DAMP administrator, are not known by DAMP personnel but seem to be based on the needs of the clinic for training and educational purposes. The DAMP administrator stated that there are no written policies for patients, referring physicians, or even the DAMP office itself.
- At the UTMB clinics, monitors were told that UTMB does not provide free care and that patients who cannot pay or do not have health insurance are referred to the 4Cs clinic and other non-UTMB sites. Some monitors were told that there is an application for health care services online. Hospital personnel reported there is “absolutely no free care” and everyone must be financially screened to determine a copayment.
- No written policies were made available to the monitors regarding eligibility for charity care or financial assistance. No charity care or financial assistance policies were available online. An application for financial assistance was available online.

Research on Hospital Policies on Charity Care and Financial Assistance and UTMB Obligations Regarding Charity Care and Financial Assistance

- In a national survey of hospital executives, over half reported that their hospital posted charity care policies online, two-thirds posted the policy in public places, and over three-fourths provide the policy on admission.
- The University of Texas Medical Branch signed a pledge in 2004 to adhere to the American Hospital Association’s guidelines and principles on hospital billing and collections that included making policies on charity care and financial assistance publicly available and applying them consistently.
- Charity care is reported annually by UTMB to the Texas Department of State Health Services.
- Charity care and bad debt are components of “uncompensated care”, a term that is recognized as inexact, at best. The concept of uncompensated care is that it is care given where no payment is received. Designating such care as charity has an enormous impact on people as compared to designating such care as bad debt.
- UTMB reports to the Texas Department of State Health Services that there is a charity care policy and that it includes a formal eligibility system.
- All hospitals in Texas must comply with a law, effective September 1, 2007, known as “Consumer Access to Health Care Information,” that requires hospitals to develop, implement, and enforce written policies that must address any discounts to the uninsured, and any discounting provided to a financially or medically indigent person or a written charity care policy. The law requires

posting notice of the availability of the policies in waiting areas, registration areas, and admission or business offices.

Research on the UTMB Processing Center for Uninsured and Underinsured Patients

- In two-thirds of the surveys, monitors spoke to personnel in the DAMP office. Information on whether the DAMP office currently exists is conflicting. However, the DAMP office was perceived by most survey responders to be the place to refer all questions regarding free or reduced cost care and operation of the DAMP office may provide a clue as to future approaches to uninsured people.
- In over ten years of operating DAMP, no written policies for patients, referring physicians, or internally for the DAMP office were created regarding who would be accepted for care.
- The DAMP office has functioned in three tiers: 1) financial screening and copayments, 2) departmental caps on the number of uninsured patients accepted, and 3) referral judgments.

Research on Required Payment Levels at UTMB for Uninsured and Underinsured Patients

- When the DAMP office was created in 1998, patients with the lowest incomes would be responsible for an upfront payment of 25 percent of the standard charge and would be billed for a total of 50 percent of the standard charge.
- In 2003 uninsured people with the lowest income paid \$30 for an outpatient visit and, in 2008, uninsured people with the lowest income paid \$40 for an outpatient visit. The income eligibility level has not been disclosed to the public.
- The lowest income people pay more than people with health insurance coverage through Medicaid and Medicare and people in these low income categories pay about the same as people who have private health insurance.
- The amount of hospital services charged to uninsured people above 250% of the federal poverty level was about twice as much as people with commercial insurance, according to a UTMB financial officer in 2006.
- With the exception of children, health care services are denied for uninsured people unless an upfront payment is made. Requiring upfront payments is not a common practice. According to an Internal Revenue Service survey, 85% of hospitals did not require payment prior to providing inpatient, outpatient, or emergency room services.

Research on Required Reporting of Charity Care by UTMB

- It is not clear that any health care services adhering to DAMP payment procedures and the Deposit Guide for Services at UTMB could be referred to as charity care under one definition of charity care on the Annual Hospital Survey provided to the Texas Department of State Health Services. That definition is:

Health care services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

In 2006, under this definition \$161,265,948 was reported in charity charges and, in 2007, \$152,955,359 was reported in charity charges. The one case where no hospital can refuse to care for uninsured patients regardless of ability to pay is when there is a condition deemed to be a medical emergency. This law does not prohibit hospitals from billing patients for emergency treatment.

- There are few references to charity care by UTMB. One reference to the term “charity care” refers to patients from counties contracting with UTMB. This raises at least two questions about who is included by UTMB in the reporting of charity care. The first question is whether charity patients reported on the Annual Hospital Survey receive *services free of charge* and the second is whether patients funded by county contracts are designated as charity patients. A legislative work group recommended that these funds be reported as sources of payment.

Research on Public Funds for “Un-sponsored Care”

- According to Navigant Consulting, in 2006, funds internally allocated for unsponsored care paid the hospital at a rate that was 113% of the Medicare rate and paid the physicians at a rate that was 147% of the Medicare rate.
- In 2006, revenue supporting unsponsored care at UTMB almost entirely covered the cost of unsponsored care, leaving a deficit of \$40,000.
- The DAMP process can be considered a process of allocation of funds, rather than a process of rationing. In 2006, of the \$118.96 million allocated for unsponsored care, \$111.41 million was public funding and \$7.55 million was derived from patients’ cash payments.

Research on the Relationship of Charity Care to Bad Debt

- It is not known whether charity care is available or whether any person is told about charity care if it is available. However, at UTMB charity care has declined proportionate to an increase in bad debt. From 2005 to 2008 the amount of services designated as charity care has declined by 36% and the amount of

services designated as bad debt has increased by 44%. Since 1999, charity care has declined by one-half as a percentage of revenue, from 20.6% to 10.7%.

- Medical debt can have devastating consequences for patients and for families.
- DAMP rules are credited with the creation of computer “bad-debt flags.” A staggering 64,000 people were subject to bad-debt flags in 2003. These flags do not allow an appointment to be made, except under certain circumstances. For accounting purposes, the Healthcare Financial Management Association recommends recording bad debt only when collectibility is reasonably assured.
- DAMP procedures included other bureaucratic barriers such as an off-campus location and “hard-blocks” that prevent follow-up appointments after an emergency department visit.

Research on Referral Judgments and Priority Setting

- Referral judgments are made by financial screeners based on visually scrutinizing patients.
- Referral judgments are also made by area medical directors based on paper forms from health care providers who have determined that specialty services are needed.
- There is no publicly available information on how referral judgments are made or on what basis priorities are set, except that reducing uncompensated care costs and teaching or educational needs have been mentioned. In the first seven months of 2006, 4,423 patients were excluded from health care services while 5,863 were accepted for appointments.
- Priority setting in health care is of deep concern to many Americans and to congressional leaders. The process of deciding who receives care and who is excluded is often considered to be as important as the criteria developed for decision making. Transparency, fairness, and openness to revision are vital to priority setting.
- The basis for decision making in hospitals for the care of uninsured patients should revolve around consistency.

Research on How UTMB Procedures for the Uninsured and Underinsured Affect Galveston County Residents

- DAMP procedures in Galveston County have resulted in an inability of residents whose physicians have determined specialty care is needed to obtain those services in over three-fourths of cases.
- Providers of health care services by public hospitals and community health centers are highly interdependent. In Galveston County, implementation of DAMP affected the community health centers' ability to refer mutual patients for needed specialty services.
- Several terms used to refer to health care for the uninsured and sources of funding for the uninsured can obscure as many details as they describe. For example, if only the term "uncompensated care" is used, charity care could decline to zero and the total amount could be comprised only of bad debt. Another source of confusion is that "indigent health care" and "unsponsored health care" can both be categories of specific patients and sources of funding. For example, "indigent health care" could refer to funds received through County Indigent Health Care sources or unclaimed lottery funds designated for indigent health care.
- The lack of publicly available policies on charity care and reduced cost care combined with high levels of copayments, billing the uninsured at rates higher or comparable to the commercially insured, bureaucratic barriers, opacity of priorities and criteria for acceptance for specialty care, and nondisclosure of public financing, all contribute to difficulties in access to health care in Galveston County.

Recommendations:

- UTMB should, as required by the Texas Health and Safety Code, post notice in waiting areas, registration areas, and admission or business offices about the availability of written policies on charity care and financial discounts.
- UTMB should, as evidence of their commitment to the American Hospital Association's guidelines and principles, apply the charity care and financial discount policy consistently. The hospital should communicate information about the policy in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in the community. The policy should be shared with appropriate community health and human services agencies and other organizations that assist people in need. All staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) should be educated about hospital billing, financial assistance, and collection policies and practices.

- UTMB should publish its charity care and financial assistance policies annually in the Galveston County Daily News.
- Health policies developed by UTMB regarding uninsured or underinsured patients should have publicly available written policies. Such policies should be evaluated and revised based on their effects on the health of patients.
- Charges billed to the uninsured or underinsured should be based on written policies and applied consistently. At a minimum, eligibility for designated charity care should apply to all patients with incomes below the federal poverty level. Templates for developing and applying financial assistance procedures are available from a number of organizations, including the Texas Medical Association, the American Hospital Association, the Healthcare Financial Management Association, Community Catalyst, PriceWaterhouse Cooper, and many others.
- UTMB should determine eligibility for charity care as soon as possible when health care services are needed and revise the eligibility based on continued circumstances. UTMB's charity care policy should address situations in which not all income or other information is available from the patient.
- UTMB should make every effort to identify patients eligible for charity care and distinguish eligible patients from people whose accounts are considered bad debt.
- UTMB should either not impose copayments for health services on people whose income is below the federal poverty level, or allow waiving of these copayments without incurring a medical debt.
- Internal payment levels should be cost based so that available public funds are used to care for the maximum number of patients possible.
- UTMB should report the sources of public funding for services to the uninsured and underinsured and the residual deficit or surplus.
- The allocation of public funds should be made through a transparent, public process that is accountable to the public, particularly the local community.
- UTMB's reporting of charity care on the Annual Hospital Survey should correspond to the definitions explained on the survey.
- Bureaucratic barriers, "hard-blocks," bad debt flags, and denial of services for people without cash payments place excessive burdens on uninsured and underinsured patients, create an adversarial relationship, and have strong negative health consequences. UTMB should discontinue these practices.

- UTMB should reconsider its role in the health of Galveston County residents and the shifting of health care responsibilities to the 4Cs clinics where available providers are one one-hundredth of the providers available at UTMB.
- UTMB should report information on health care for the uninsured and on funding for the uninsured so that transparency is achieved. In the case where terms used have variable and inconsistent meanings, these should be explained to the public.
- UTMB should strive to achieve transparency in health policies and practices and accountability to the public for those policies and practices.

CHRISTUS St. John Hospital

Christus St. John Hospital is a 170-bed full-service acute care hospital located across from NASA Johnson Space Center in Nassau Bay. There are more than 400 physicians on the medical staff and almost 700 associates. Established in 1981 as a part of the ministry of the Sisters of Charity of the Incarnate Word, Christus St. John Hospital provides a broad spectrum of adult and pediatric medical, surgical, and obstetrical care, as well as numerous ambulatory services.¹⁶⁶

Findings:

- In two phone surveys of Christus St. John Hospital, monitors were told that no free care was available. In a site visit to the hospital, a written policy on charity care was provided.
- Beginning in FY 2006, all Christus Health Regions waived charges for uninsured patients with incomes up to 200 percent of federal poverty guidelines (FPL) and offered discounts to those without insurance with incomes greater than 200 FPL. Total charity care provided was 7.4 percent of net patient revenue.¹⁶⁷
- Christus St. John Hospital is a nonprofit hospital that must abide by certain state and federal laws. The Texas Charity Care Law was enacted in 1993 out of public concern over whether nonprofit hospitals were providing health care services to low income patients consistent with their tax-exempt status.¹⁶⁸ National concern over this issue has continued. The Internal Revenue Service has implemented changes in the reporting requirements of tax exempt hospitals beginning in 2009.¹⁶⁹

¹⁶⁶ *Christus St. John Hospital* (2009 [cited September 29 2009]); available from <http://www.christusstjohn.org/index.htm>.

¹⁶⁷ *Christus St. John Hospital: About Us* (2009 [cited September 1 2009]); available from <http://advocacy.christushealth.org/aboutUsCommitment.html>.

¹⁶⁸ Texas Health and Safety Code, Section 311.045

¹⁶⁹ Eileen Salinsky, "Schedule H: New Community Benefit Reporting Requirements for Hospitals," in *National Health Policy Forum Background Paper No. 67* (Washington, D.C.: George Washington University, 2009).

Clear Lake Regional Medical Center

Clear Lake Regional Medical Center is a 595-bed tertiary regional referral center offering a comprehensive array of medical services for the region's growing population. The hospital is a six-story complex with three patient towers and the Heart and Vascular Hospital located across the street from the towers.¹⁷⁰

Findings:

- In three phone surveys and a site visit of Clear Lake Regional Medical Center monitors were told that no free care was available. No written policies on free or reduced cost care were provided. No signs were posted regarding the availability of written policies on charity care or financial discounts.
- Clear Lake Regional Medical Center is a Hospital Corporation of America affiliate.



¹⁷⁰ *Clear Lake Regional Medical Center* (2009 [cited September 29 2009]); available from <http://www.clearlakermc.com/>.

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