

# Metropolitan Atlanta Hospital Accountability Project

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A program of nonprofit consumer advocacy organization Georgia Watch, the Metropolitan Atlanta Hospital Accountability Project examines the financial practices of metropolitan area not-for-profit and for-profit hospitals in regards to health care access and affordability.

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## About the Project

In January 2009, Georgia Watch was awarded a two-year grant by Community Catalyst, a national nonprofit advocacy organization, to study health care accessibility in metropolitan Atlanta. The resulting program – the Metropolitan Atlanta Hospital Accountability Project – has focused on financial aid programs for low-income, uninsured and underinsured patients.

In the study, we evaluated acute care facilities in 21 counties. Critical access hospitals and specialty facilities, such as long-term care facilities and children’s hospitals, were not examined. We examined hospitals and health systems in the following counties: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding and Walton.

We sought input from each hospital studied in the report, and all hospitals were invited to submit a narrative of the challenges they face providing access to affordable care for uninsured and underinsured consumers. Hospitals that participated were given a preview copy of the report and invited to comment on any information before it was made publicly available.

In addition, we surveyed approximately 900 low-income, uninsured or underinsured consumers about their financial experiences at area hospitals, medical bills and perceptions of health care finance. HAP collaborated with coalition partners WonderRoot, Concerned Black Clergy and area clinics to conduct the surveys on site, online and at local community events during a six-month period in 2009. The surveys were conducted in both English and Spanish.

We also visited each of the metropolitan Atlanta hospitals examined in the project to determine whether signage and materials regarding financial assistance options were visible to the general public and/or available upon request. These site visits were conducted April 12-27, 2010.

All additional information in the report was either culled from publicly available documents or provided by the hospitals. The Department of Community Health’s Annual Hospital Questionnaire, Centers for Medicaid and Medicare data, Internal Revenue Service filings and not-for-profit hospital and health system reports were most often used.

## Executive Summary

The face of the metropolitan Atlanta area's uninsured and underinsured is diverse and evolving. People who have been employed gainfully for decades are now, because of the economy, unable to support themselves and their families, and can't afford health insurance. The so-called young invincibles, the nearly poor, those working in certain industries and those with chronic conditions continue to remain off the rolls of private and public insurance. For those who do have insurance, coverage is often inadequate, and continues to dwindle as health costs rise. Preventive care and necessary screenings can be out of reach for those with private insurance, and deductibles are often prohibitively high.

Low-income, uninsured and underinsured consumers face formidable obstacles to affordable health care, including high mark-ups on hospital charges and a lack of clear information about available financial assistance at hospitals, as well as transportation, language and specialty care needs.

In our research of issues surrounding affordable care and hospital practices and policies in the metropolitan Atlanta area, we found that:

- In 2008, metropolitan Atlanta hospitals marked-up their costs an average 235 percent increase, though price hikes at some facilities reach as high as 714 percent;<sup>1</sup>
- That year, the two most expensive hospitals in the metropolitan area were North Fulton Medical Center and Cartersville Medical Center, and the two most affordable were Walton Regional Medical Center and Grady Memorial Hospital;
- Metropolitan Atlanta hospitals provided a total \$293.7 million at cost in uncompensated care in 2008, a small percentage (2.17 percent) of their collective annual adjusted gross revenue;
- Grady Memorial Hospital and Barrow Regional Medical Center provided the highest level of free care for poor people, while Piedmont Hospital and North Fulton Medical Center were among those who provided the least;
- Only one-half of the 34 hospitals examined had clear signage placed at some part of the hospital advertising the availability of free or reduced-cost care for uninsured and/or low-income persons;
- Eighty percent of the approximately 900 consumers surveyed for this project said they had no form of insurance, and two-thirds of those individuals said they had no regular source of care;
- 72 percent of the consumers surveyed who identified themselves as underinsured said they often delay preventive and other care due to the fear of the cost, as they are uncertain whether they can pay their part of a hospital bill; and,
- The amount of uncompensated care rendered varies greatly from hospital to hospital, even in a shared service area. For example, Grady Memorial Hospital provided about 62 percent of all uncompensated care in Fulton County, though it is only one of ten acute care facilities.

As key health care providers that offer a wide range of services, hospitals have a unique opportunity to help reduce access disparities for low-income, uninsured and underinsured populations. By advertising the availability of available financial assistance and providing copies of its financial assistance policies, hospitals give consumers the opportunity to be fully aware of their fiscal options before care begins. By enacting programs that help reduce barriers to health care access, such as screenings with appropriate follow-up care and health education, hospitals can boost the overall fiscal and physical health of its community.

In addition, if hospitals helped low-income, uninsured and underinsured patients access affordable health care, the need for charges that substantially exceed actual costs would be reduced and would result in more affordable bills that are more likely to be paid. If a bill is unaffordable, both the hospital and the patient are

negatively affected (i.e., the hospital is much less likely to receive payment, and the patient is likely to forgo future treatment needs, experience stress and face poor credit and debt collection actions).

Metropolitan Atlanta hospitals are able to address the barriers to affordable care that confront uninsured, underinsured and low-income consumers by working within their facility, the community and lawmakers to enact policies and create programs that will better the fiscal and physical health of their hospitals and patients.

### ***Suggested legislative and organizational policy changes***

**Oversight:** Increased oversight on state and federal patient financial assistance programs is crucial to ensure compliance with existing laws, particularly those laws specific to hospitals that participate in the Indigent Care Trust Fund program (ICTF). Georgia’s Department of Community Health (DCH) should conduct regular audits of filings made by hospitals to the Annual Financial Survey, and audits of reported indigent care expenditures by hospitals that participate in the ICTF.

**Assessments to evaluate the real value of tax-exempt status:** County taxing authorities should annually assess the property holdings of tax-exempt not-for-profit health care facilities to ensure the community is receiving a comparable benefit for the loss of its property tax revenue.

**Availability of written financial assistance policy:** A written copy of a hospital’s financial assistance policy and income guidelines must be made available upon request, per ICTF obligations. The policy must include income eligibility thresholds and other information about the hospital’s financial assistance policy. This information must be written in clear and easy-to-understand language, and must be provided in the languages appropriate for the populations a hospital serves.

**Signage indicating the availability of financial assistance:** Hospitals must ensure signage indicating the availability of financial assistance is placed at key areas throughout the hospital – the admissions desk, the emergency room, the financial office and the cashier’s desk, for example. Hospitals receiving Indigent Care Trust Fund dollars are required to post signage indicating the availability of financial assistance, and hospitals must comply with this regulation.

**Appropriate financial counseling:** Patients should receive appropriate financial counseling that is conducted in a one-on-one manner that ensures their information is kept confidential, and therefore does not violate both the Health Insurance Portability and Accountability Act (HIPAA) and basic privacy rights. Patients should not be forced to discuss their financial situation at a cashier’s window or through other such partitions, as information could easily be overheard, and may act as a deterrent to a patient inquiring about assistance.

**Fair patient billing:** Patient charges must be fair and clearly explained at the time of hospital admission, and this information must be made available to patients in the language they will most easily understand. Collection policies and practices should be fair, and the hospital must seek to avoid collection procedures. Hospitals may not pursue actions for non-payment of a hospital bill against a low-income, uninsured or underinsured patient who demonstrate they have neither income nor assets to meet their financial obligations, provided the patient has complied with their responsibility to provide relevant and necessary information as required by the ICTF.

## Introduction to the issues

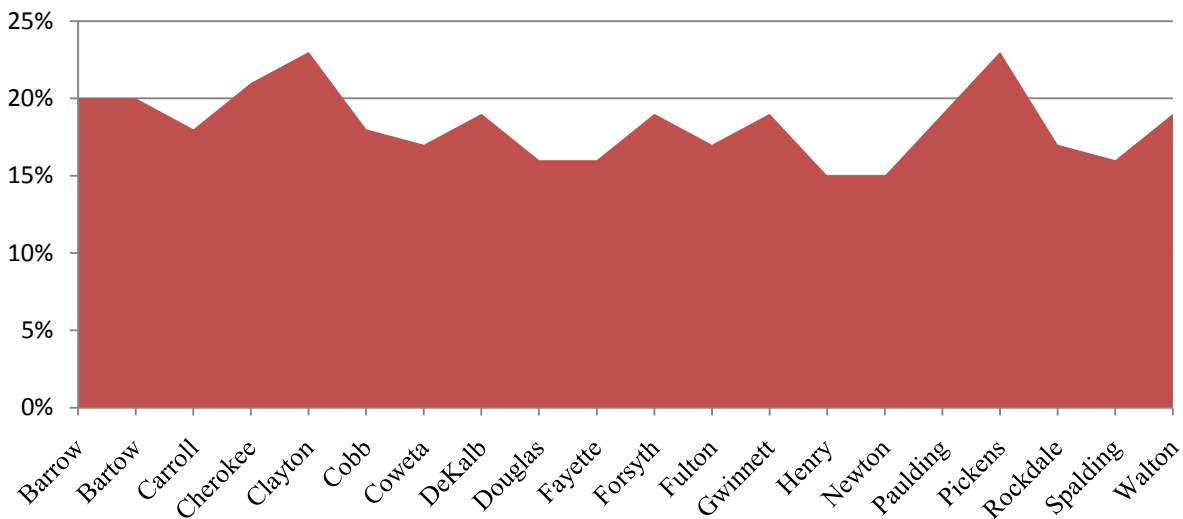
Insurance status is a key determinant in a consumer’s ability to afford needed health care, and those that have no form of insurance, whether private or public, are especially affected, though each group has its own particular challenges.

### The uninsured

In the past several years, numerous studies have illustrated the correlation between a lack of insurance and poor health, as those without insurance are less likely to receive adequate care in a timely manner, and are also more likely to forgo preventative tests and health screenings due to the anticipated cost.

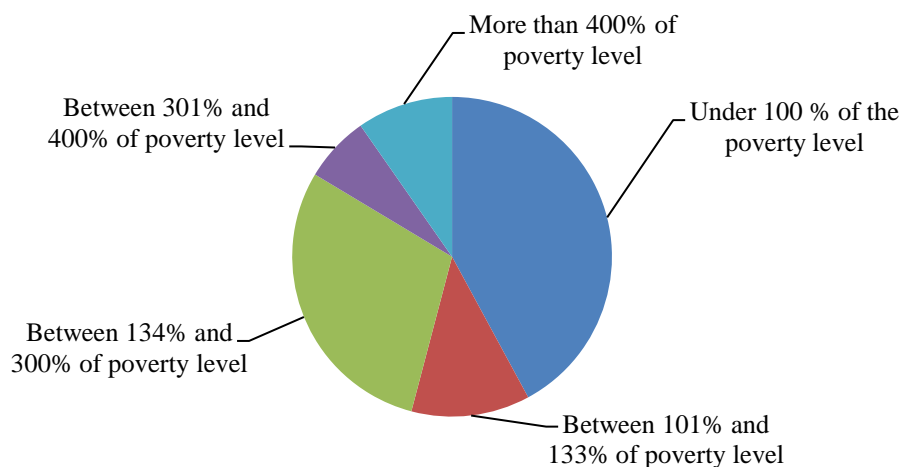
Some counties have higher levels of uninsured patients than others. Of the counties studied, Pickens County and Clayton County have the highest level of uninsured patients – about 23 percent of its total residents. Barrow and Bartow counties follow closely behind with 20 percent of its residents as uninsured.

**County by county uninsured rates**



As demonstrated in the below chart, more than half of Georgia’s uninsured live at or just above the poverty level.<sup>iiii</sup>

**Income and poverty levels**



Georgia ranks fifth for the number of premature deaths due to lack of insurance – an estimated 11,500 in 2009,<sup>iv</sup> and ranks among the top ten among states for citizens that avoid preventive care due to high cost and a lack of insurance. Uninsured people are more likely to skip screenings and other preventive care, so their medical problems are often diagnosed later, when they are more advanced and tougher to treat. The uninsured are also more likely to skimp on necessary medical care, whether it is prescription drugs to keep their blood pressure in check or surgery to clear up clogged arteries.<sup>v</sup>

**In a survey of 900 metropolitan area consumers, approximately 720 reported themselves as uninsured and, of those, 70 percent said they went without needed care, such as skipping a test or treatment recommended by a doctor or not filling a prescription because of cost. Sixty percent of the surveyed uninsured worked at least part-time.**

Those who live at, below or just above the poverty level are often eligible for financial assistance through government programs, but many uninsured patients who qualify for federal and state financial assistance programs do not utilize them. For example, in Fulton County, an estimated 20 percent of the county’s uninsured population qualified for existing public options such as Medicaid or PeachCare in 2007 but were not enrolled, for whatever reason.<sup>vi</sup> In addition, approximately 35 percent of the county’s uninsured – about 560,000

people – need some financial assistance when attempting to afford their medical bills.<sup>vii</sup>

Consumers aren’t the only ones affected by unpaid medical bills. Hospitals that subsidize care for Georgia’s uninsured, particularly those that attend to a disproportionately high number of these patients, and can incur a crippling amount of debt due to the subsidies. Considered “safety net” facilities, these hospitals serve the area’s uninsured. For some patients, federal, state and local governments will subsidize the health care costs through special programs. But uninsured patients not eligible for indigent or charity care may burden safety net hospitals with unpaid and uncollectible debt.

There are approximately 1,300 public safety net hospitals in the country – 300 fewer than 15 years ago. Many have closed due to financial strain, including facilities in Los Angeles, Washington, St. Louis and Milwaukee. In Georgia, Grady Memorial Hospital is the state’s largest safety net hospital.

According to the National Association of Public Hospitals, safety net members account for two percent of all hospitals but provide 25 percent of the nation’s uncompensated care. Public hospitals in major metropolitan areas, including Chicago, Miami and Memphis, currently face severe financial shortfalls and must receive immediate assistance to delay or stop closure. Others, like Grady Memorial Hospital, have restructured to survive.

In December 2008, Southern Regional Medical Center almost closed due to the cost of care for its uninsured patients, who comprised a significant percent of its total patient load. The hospital provided about \$80 million in indigent care that year. Deep in debt, the hospital was seemingly out of options when it was unable to repay a \$40.2 million loan owed to SunTrust Bank.<sup>viii</sup> In January 2009, the Clayton County Commission voted to back the debt, which allowed the hospital to remain open.<sup>ix</sup>

### **The underinsured**

Many who have health insurance are considered underinsured because they lack sufficient coverage. By definition, the underinsured:

- Spend at least 10 percent or more of their annual income on health care costs;
- Live below 200 percent of the poverty level and spend more than 5 percent of their income on medical costs; and,
- Pay deductibles of 5 percent or more of their total family income.

Community Catalyst reported in April 2009 that an estimated one-fifth of all insured adults in the US – about 25 million citizens – were underinsured in 2007.<sup>x</sup> This vulnerable group of Americans has grown by 60 percent since 2003. The number of underinsured is much greater in the low-income population that our survey focused on. Of the 900 consumers surveyed for this report, approximately 180 identified themselves as insured, but 155, or 86 percent, identified themselves as underinsured. Most said they often delay preventive and other care due to the fear of the cost, because they are uncertain whether they can pay their part of a hospital bill. According to PricewaterhouseCooper's Global Healthcare Research Institute, many people with inadequate insurance delay or forgo medical care until it becomes an absolute emergency.<sup>xi</sup>

Having insurance, even a plan that is inadequate, can prohibit a patient from accessing financial assistance. A lack of insurance can serve as a signal to hospital staff to screen the patient for assistance programs, or a patient might assume they are ineligible because they do have some insurance. Without financial assistance, patients may be unable to pay their bill.

Unpaid hospital bills increase costs for the government, insurance companies, employers, employees, and the self-insured because hospitals raise rates to offset bad debt. In response, commercial insurance providers raise premiums to cover cost increases. These increased insurance premiums cause employers to shift the burden of increased premiums to their workers and charging steeper deductibles.

**As the cost of premiums rise, so does the number of underinsured Americans who can't afford high deductibles and co-pays for hospital and emergency room treatment. Those shortfalls in payments are then shifted to government, private insurers and self-pay patients, continuing the vicious circle.**

### **Poverty and access**

The correlation between income and health is deep and varied; many factors can lead those with low income to poor health, including limited access to low-cost care, lack of transportation options to access timely care, increased likelihood of having a dangerous job and unhealthy lifestyle habits.

Low-income persons spend their limited income first on basic necessities such as food, clothing, and housing, which leaves no additional funds for health care, especially private insurance and preventive care. Low-income individuals are more likely than their richer counterparts to suffer from chronic illness, to become disabled and to have a shorter life expectancy.<sup>xii</sup>

Poorer individuals are much more likely than higher-income individuals to lack insurance, and account for nearly two-thirds of all uninsured consumers. Low-income workers are less likely than those with high incomes to have employee-sponsored health insurance. Private insurance, which costs on average \$6,000 a year for a family, is often prohibitively expensive.

Low-income individuals are more likely than their nonpoor counterparts to smoke, and to suffer from obesity due to a lack of exercise and poor eating habits.<sup>xiii</sup> Low-income families and individuals have limited food budgets that may lead them to eat inexpensive foods which are often high in trans fat, saturated fats and refined sugars. Fresh produce may be limited or unavailable in poor and rural areas, leading many families to shop at grocery and convenience stores that have expensive or limited healthy options.

### ***Unemployment and insurance***

The Consolidated Omnibus Budget Reconciliation Act, or COBRA, provides to recently unemployed eligible employees and dependants a temporary extension of health coverage where coverage under the group plan would otherwise end. These individuals are generally required to pay for coverage up to 102 percent of the cost of the health plan, including employer contribution.



In Georgia, the average monthly COBRA premium for family coverage is \$1,053, a figure that comprises nearly 87 percent of the average monthly unemployment benefit of \$1,217.<sup>xiv</sup> It would be almost impossible for most Georgia families to afford that sort of extended coverage as, it is estimated, that food, utilities and housing makes up 64 percent of an earner's paycheck.<sup>xv</sup>

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, provides for premium reductions for health benefits COBRA. Eligible individuals pay only 35 percent of their COBRA premiums and the remaining 65 percent is reimbursed to the coverage provider through a tax credit. To qualify, individuals must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment.

### ***Insurance premiums***

Health insurance premiums for Georgia's working families increased by 72.5 percent from 2000 to 2007, rising seven times faster than median earnings.<sup>xvi</sup> By contrast, Census figures show that the economic cycle that began in 2000 and ended in 2007 was one of the weakest on record for working families,<sup>xvii</sup> leaving many unable to afford their medical bills.

### ***Medical debt***

Medical debt weighs heavily on our families. According to a June 2009 national study of foreclosures during the preceding 24 months, approximately half were due, in part, to high medical bills incurred from illness and injury, unmanageable medical bills, lost work due to a medical problem and caring for sick family members.

**"Unless you're a Warren Buffett or Bill Gates, you're one illness away from financial ruin in this country," says lead author Steffie Woolhandler, M.D., of the Harvard Medical School, in Cambridge, Mass. "If an illness is long enough and expensive enough, private insurance offers very little protection against medical bankruptcy, and that's the major finding in our study."**

According to a January 2007 report:

- Nationally, average credit card debt was higher for low- and middle- income households as compared to these same households without a major medical expense in the previous three years;
- Average credit card debt was higher for those without health insurance (\$14,512) than for those with health insurance (\$10,973); and,
- The medically indebted are more likely to be called by bill collectors than those without such medical expenses (62 percent versus 38 percent).<sup>xviii</sup>

Nationally, bankruptcies due to medical bills increased from 46 percent in 2001 to 62 percent in 2007, and most of those who filed were middle-class, well-educated homeowners, according to a report published in the August 2009 issue of *The American Journal of Medicine*.<sup>xix</sup> According to several studies, approximately two-thirds of those who have fallen into foreclosure or filed for bankruptcy because of medical debt had insurance at the onset of the illness that led to their financial devastation.

## **Barriers and Challenges**

Consumers face many formidable obstacles when attempting to access care, including, but not limited to, a lack of available specialized care, such as care for chronic conditions or mental health services. Certain barriers can be high hurdles in accessing care for all individuals, but low-income, uninsured and underinsured populations may be disproportionately affected due to socioeconomic factors that may affect them particularly.

### ***Accessing mental health care***

It is difficult to access adequate and affordable mental health care without insurance, and even those with insurance may find themselves without many options. In the metropolitan Atlanta area, a few hospitals do offer outpatient mental health care, such as Grady Memorial Hospital, which operates the Central Fulton Community Mental Health Center. The hospital also provides emergency psychiatric services and referrals for patients residing in Fulton and DeKalb counties. Tanner Health System operates Willowbrooke at Tanner, which offers to patients both inpatient and outpatient mental care.

Clinic offerings for mental health care are also limited. In May 2010, at least three local community health centers ceased their mental health services for working poor and homeless people in Fulton County,<sup>xx</sup> significantly reducing options for individuals seeking these services in the immediate metropolitan Atlanta area. Other counties face similar limited options, as funding for such services tends to be low.

### ***Accessing care for chronic conditions***

One out of every three working-age uninsured Americans suffers from a chronic illness and isn't getting needed care, according to a report published in the *Annals of Internal Medicine* in 2008.<sup>xxi</sup> Uninsured adults with chronic conditions are two to four times less likely to receive medical attention than insured adults with the same conditions. This lack of adequate care can lead to steep and swift declines in health. According to the report, uninsured adults are 40 to 50 percent more likely to die prematurely from serious conditions such as heart disease, diabetes or cancer than those with insurance. Overall, uninsured adults are 25 percent more likely to die prematurely than insured adults overall.

According to the Georgia Free Clinic Network, 80 percent of free clinic patients have one or more chronic illnesses, requiring extensive and ongoing medical care, care coordination and patient education. The Network provides a specialty care referral network, though many volunteer clinics have limited capacity to offer care for chronic conditions such as epilepsy and cancer. However, a few clinics offer specialized care, such as prenatal care and ongoing diabetes maintenance.

### ***Accessing critical care when homeless***

Medical respite care is defined as short-term medical and recuperative services for homeless people who are too ill to live on the streets but not sick enough to warrant a hospital stay. In the metropolitan area, only one clinic offers respite care – Saint Joseph's Mercy Care Services at the Gateway Center, a temporary and transitional housing facility for the homeless. Opened in October 2008, the 19-bed unit provides nursing care to qualified patients for up to 30 days. . The program is open only to adult homeless males who have no income. Mercy Care, Gateway Center and Grady Health System are the central collaborators on the project, and Grady provides the patient with required medication during his stay. In addition, Emory University nursing school faculty and students volunteer at the clinic.

### ***Accessing care when there are language barriers***

Communication is a key component in the delivery of quality care at hospitals, and the absence of proper dialogue is easily a barrier for many patients. According to the Joint Commission's Sentinel Event Database, communication problems are the most common cause of pernicious events.<sup>xxii</sup> Communication barriers generally fall into two categories: foreign language and health literacy.

In a nationwide study of more than 2,700 limited English-speaking patients, researchers found that language barriers between patients and health care providers result in longer hospital stays, more medical errors and lower patient satisfaction.<sup>xxiii</sup> In addition, patients who do not speak the same language as their doctors are less likely to receive lifestyle counseling, such as diet consulting and smoking cessation counseling.<sup>xxiv</sup>

“When it comes to communicating with patients in the hospital setting, mistakes can be costly and potentially deadly,” says Linda Joyce, a language access consultant and the former Director of Language

Interpretive Services at Grady Health System in Atlanta.<sup>xxv</sup> “While facilities are conforming to regulatory and legal requirements, many are doing so only with a patchwork system, relying on medical staff who happen to speak another language, or turning to family members of patients to help with interpreting.”<sup>xxvi</sup>

There were about 738,000 metropolitan residents who do not speak English at home, according to the 2008 Census. This number fails to capture the actual number of limited English-speaking residents because it captures only 13 of the 21 counties studied. In addition, the Census numbers under report the number of foreign born residents.

Many hospitals utilize audio and video translation services for medical professionals, such as the Language Line, which is the leading provider of such services. The demand continues to grow. From 2006 to 2007, medical interpreting usage increased 20 percent nationally among its clients.<sup>xxvii</sup>

**Of the 290 Spanish speaking uninsured and underinsured consumers surveyed for this report, approximately 72 percent said they felt language was a barrier when attempting to access both care and financial assistance at their hospital, and 25 percent said they were not given financial information in their native language.**

But information on available financial assistance is often limited, and few hospitals staff translators to explain the details of apply for such aid. Hospitals receiving Indigent Care Trust Fund monies are required to post signage in languages appropriate for their patient base, though only a few facilities had bilingual postings, and of those, none had signage in languages other than Spanish and English.

Low health literacy can also prove to be a formidable barrier, and can be present in anyone, regardless of their nationality. Defined as a the level to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions, health literacy skills can vary from person to person and is not necessarily related to education or general reading ability.<sup>xxviii</sup> For example, a person who functions

adequately at home or work may have marginal or inadequate literacy in a health care environment. Conversely, someone with a limited education may fully understand diagnosis and medication dosage information, as may someone who does not speak English as a primary language.

When a person does speak the same language and is of the same culture of the clinician who delivers the care, and does not ask questions regarding their care, the clinician may presume the patient understands the diagnosis and recommended treatment.

### ***Accessing care with transportation barriers***

Many consumers attempting to access health care do not have a car or access to public transit to access prompt, needed care. Of the approximately 900 uninsured and underinsured consumers surveyed, 23 percent reported they used either public transit or the help of others with vehicles to access care, because they had no reliable means of transportation to seek out low-cost options.

The Metropolitan Atlanta Rapid Transit Authority, or MARTA, serves Fulton and DeKalb counties by operating a limited rail line and bus lines—38 rail stations and 131 bus routes.<sup>xxix</sup> Currently, the cost to ride Marta is \$2, and the card on which to store your trip fare costs either \$0.50 for a temporary card or \$5 for a permanent card. Reduced fares are available to senior citizens, those on Medicare and/or those with a physical or mental disability.

MARTA provides Americans with Disabilities (ADA) paratransit service to eligible persons with disabilities who are unable to board, ride or disembark from an accessible vehicle in MARTA's regular bus or rail services. Service is provided with special lift-equipped vans on a curb-to-curb, shared ride basis. MARTA Mobility costs \$3.60 per trip, and MARTA for Medicaid recipients is only \$0.90 per trip.

Rail service does not have the same curb-to-curb capacity as MARTA Mobility, and stops near hospitals are rare. Of the 32 hospitals examined, only four are within short walking distance of a MARTA rail station. The Medical Center station is adjacent to Saint Joseph’s Hospital, and is within a short walking distance of Northside Hospital. The Georgia State rail station is one block from Grady Memorial Hospital, and Emory University Hospital Midtown is within a block of the North Avenue station.

There are some bus routes that ride near clinics and hospitals such as bus route 185 to North Fulton Regional Hospital from the North Springs rail station and the Emory Clinic on bus route 245 from the Lindbergh Center rail station.<sup>xxx</sup> Unfortunately, there is no rail service near a hospital or clinic on the immediate west and south lines.

As MARTA struggles with a \$120 million budget deficit, even this limited service could increase in cost or be cut altogether. MARTA receives revenue from a 1 percent sales tax in Fulton and DeKalb counties, and that revenue has, in recent years, greatly declined. Projected cuts to service will be deep – more than half of its bus routes may be limited and wait times for rail service lengthened as trains run with less frequency.

Some counties outside of the immediate metropolitan area do offer transportation options. For example, Bartow County Transit (BCT) provides transportation to those who need to go to the doctor for non-emergency reasons. The system transports a patient anywhere within the county.<sup>xxxii</sup> Cherokee County’s transportation system, the Cherokee Area Transportation System, has a two-route bus system, one of which travels to Northside Hospital-Cherokee.<sup>xxxii</sup> Cobb County Transit (CCT) and Gwinnett County Transit (GCT) serve their respective counties, and include stops near hospitals. For example, CCT provides direct service to Emory Adventist Hospital. Until March of this year transit was available in Clayton County through C-Tran, but the county commission effectively ended that service by failing to close a budget hole last fall. However, state legislation passed this year will give Clayton voters the option in July to approve an extra penny of sales tax in order to resume transit services in the county.

Some hospitals offer their own transportation options, including Northside Hospital, which reports on its Web site programs that provide financially eligible patients with taxi service, gas cards and MARTA cards for travel from the hospital, as well as free shuttle service between certain hotels and system hospitals.

Other hospitals such as Southern Regional Medical Center, Grady Memorial Hospital and WellStar Paulding Hospital offer transit services for specific services, such as cancer screening and treatment, and WellStar suggests on its Web site for patients to use Christian based transportation-Christian Air Ministry or Angel Flights, though this service is provided primarily for patients with a medical need that their nearby hospital is unable to address.

## **Atlanta’s health care delivery system**

Hospitals play the central role of the several components that comprise metropolitan Atlanta’s health care delivery system. Most patients receive care where their doctors, health plans or ambulances take them and, in rural communities, choices are limited to only one hospital serving a county or area.<sup>xxxiii</sup>

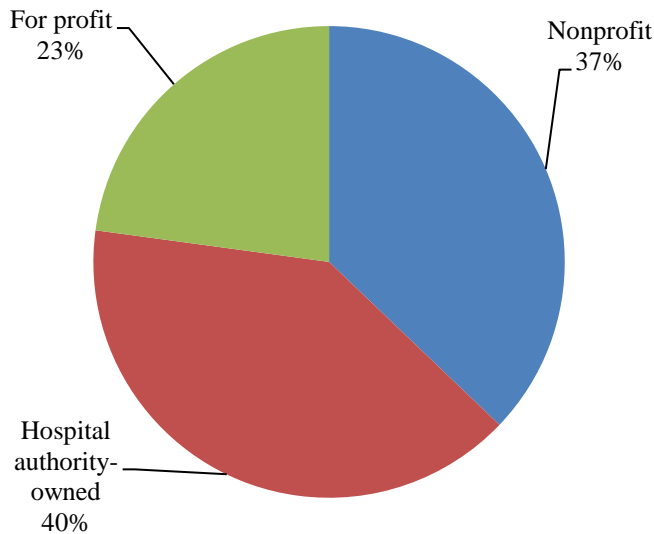
That said, the metropolitan Atlanta area does offer several choices. In the immediate four-county metro area – Fulton, DeKalb, Gwinnett and Cobb –there are 19 hospitals, though such robust offerings diminish once outside the perimeter.

Overall, there are a total 9,426 acute care, non-specialty patient beds in the 21-county metropolitan area. Not-for-profits overwhelmingly dominate for-profit hospitals in terms of how many beds hospitals own – more than 7,800 beds are owned by not-for-profit or hospital-authority facilities as compared to about 1,600 beds owned by for-profit entities.

Grady Memorial Hospital, with a total 953 beds, is the largest facility both in the metropolitan area and the state. The other large hospitals serving the metropolitan Atlanta area are: WellStar Kennestone (633 beds), Emory University Hospital (579 beds), Northside Hospital (537 beds) and Emory University Hospital Midtown (511 beds).

The smallest hospitals in the metropolitan area are Piedmont Mountainside Hospital (42 beds), Barrow Regional Medical Center (56), Walton Regional Medical Center (77 beds) and WellStar Paulding Hospital (83 beds).

### Ownership of hospitals in the metro area



**For-profit hospitals:** For-profit hospitals are investor-owned hospitals. For-profit facilities aim to make a profit from their health services, whereas not-for-profit hospitals are required to reinvest their surplus funds into their facility.

In Georgia, Tenet and Hospital Corporation of America (HCA) own a majority of the for-profit hospitals. Nationally, HCA is the largest owner of for-profit hospitals, and the chain owns three of the hospitals examined in this report – Cartersville Medical Center, Emory Eastside Hospital and Emory Johns Creek.<sup>xxxiv</sup> Tenet owns four of the hospitals studied – Atlanta Medical Center, North Fulton Medical Center, South Fulton Medical Center and Spalding Regional Medical Center. Barrow Regional Medical Center is also a for-profit facility. Atlanta Medical Center is the area’s largest for-profit hospital.

In 2009, Rockdale Medical Center was converted from a not-for-profit facility to a for-profit when Tennessee-based LifePoint hospital purchased the facility for \$80 million plus its net working capital. This purchase price gave the Rockdale County Hospital Authority needed funds to pay off debt. LifePoint also pledged to continue indigent and charity care for eligible patients and to invest \$30 million in new capital in the facility.<sup>xxxv</sup>

**Authority-owned facilities:** Many hospitals in Georgia are owned by a county hospital authority. Established by an act of the state legislature in 1969, county hospital authorities act as a transfer account for funds between the state and the hospitals. If the hospital takes on debt for construction or other ventures, the hospital authority will issue bonds and/or other financing. It has the right to approve management and contracts, and it is the only entity that can legally provide the intergovernmental transfer for Indigent Care Trust Fund (ICTF) and Disproportionate Share (DSH) funds and other such governmental funds.<sup>xxxvi</sup>

Hospital authorities also hold the lease for a hospital system’s or facility’s property, and oversee property and infrastructure decisions. By Georgia law, county hospital authorities may engage a not-for-profit entity to manage the hospital on its behalf, but the authority maintains ownership and all liabilities.

Fulton-based hospitals Grady Memorial and Northside Hospital are both owned by Fulton County’s hospital authority, which is the only such scenario in the state where two facilities are owned by the same such authority. Grady Hospital carries another unique distinction – it is the only hospital in the state that is owned by two counties, as the DeKalb County shares ownership of the hospital with Fulton County through the Fulton-DeKalb Hospital Authority.

**Not-for-profit hospitals:** Most hospitals in the state are not-for-profit entities, which are exempt from paying most taxes, including sales, income and property taxes and, because of this, not-for-profit hospitals do not contribute fiscally to vital local infrastructure, such as road and sewer maintenance, public schools or firefighter and police forces, even though these services are utilized.<sup>xxxvii</sup>

Local property tax exemptions account for the largest amount of savings for tax-exempt not-for-profit hospitals and medical facilities. The Congressional Budget Office (CBO) estimates that, nationally, not-for-profit hospitals annually receive \$12.6 billion in tax exemptions, a figure that does not include \$32 billion in federal, state and local subsidies the hospital industry receives each year.<sup>xxxviii</sup> Of the total value of those exemptions, local property tax comprises the largest percentage – about 25 percent.<sup>xxxix</sup> State and local sales tax comprises the second largest percentage at 22 percent, federal and state income tax totals 24 percent and tax-exempt bond financing<sup>xl</sup> comprises 14 percent.

In exchange for its tax-exempt status, a not-for-profit hospital is required to:

- Have a mission that will benefit its community;
- Reinvest all surplus funds in the hospital in a way that benefits the community;
- Remain accountable to the community; and,
- Remain financially accountable to the community by not allowing any portion of its net earnings to benefit any private shareholder or individual.

In addition, these hospitals must operate a full-time emergency room that is available to all people, regardless of their ability to pay; provide non-emergency services to anyone able to pay; and, participate in Medicaid and Medicare.

Among the metropolitan area's largest nonprofits are Piedmont Hospital, Grady Memorial Hospital, Gwinnett Medical Center, Saint Joseph's Hospital and DeKalb Medical Center.

### ***Newly-enacted federal law***

Through the Patient Protection and Affordable Care Act (PPACA) signed into law in March 2010, private nonprofit hospitals must now meet new standards as a condition of their federal tax-exempt status, as well as undergo increased reporting and oversight mechanisms to ensure compliance with hospital charity care and community benefit standards while increasing transparency.

Nonprofit hospitals must now: develop written financial assistance policies; limit what they charge for services; observe fair billing and debt collection practices; and, conduct regular community needs assessments. With the exception of the community needs assessment, these requirements go into effect this year, and the Secretary of the Treasury is charged with enforcing the new provisions and has authority to issue further guidance and regulations as needed to make sure they are correctly implemented.

Georgia law already requires hospitals to develop a written financial assistance policy if the hospital participates in the Indigent Care Trust Fund, or if the hospital holds a Certificate of Need, both of which are discussed later in the report.

### ***The effect on local governments***

Both authority-owned facilities and nonprofit hospitals have traditionally provided the necessary care for low-income individuals. Generally, both hospitals receive funds from local, state and federal governments to provide this care, either through direct assistance or through tax exemptions which, in theory, frees money that would otherwise be spent on taxes to now be spent on uncompensated care and other such community offerings.

Without a doubt, property and sales taxes are key drivers in local economies, and the absence of those tax dollars affects the county's bottom line. Often hospitals are among the largest employers in a given community, and while the economic impact of a hospital can prove high through this role (employee's purchasing goods and homes, etc.), the direct loss of tax funds affects schools and other government-funded services, including firefighter and police forces.

### ***Recent mergers and joint agreements***

Recently several mergers have been announced, including that of Piedmont Healthcare and Saint Joseph's of Atlanta, of which the two are reported to soon enter into a joint operating agreement to create an integrated system that would include shared physician networks, hospitals and research facilities.<sup>xli</sup> In addition, it was recently reported that Piedmont Hospital and Henry Medical Center will also partner, an agreement Henry Medical Center Chief Executive Officer Charlie Scott told the *Atlanta Business Journal* would help his facility to expand its medical services, cut costs and improve quality of care. In addition, Henry Medical could potentially expand its cardiac services, as well as offer oncology services. Scott told the *Business Journal* he felt these sorts of arrangements would become common as the current economic atmosphere makes it difficult for smaller, independent hospitals to survive.

"The economics of health care are just becoming more and more difficult, and the financial pressures are becoming greater," Henry Medical Center CEO Charlie Scott said.<sup>xlii</sup>

The details of these mergers were not been finalized or fully defined when the report was released.

**Clinics:** Clinics offer eligible patients affordable options for care, and are a formidable component of the metropolitan area health care landscape. While this report does not specifically examine clinics in terms of accountability, it is important to note their role in the metropolitan Atlanta area health care delivery system. There are four kinds of health clinics – county health departments, federally qualified health clinics, volunteer clinics and hospital-associated clinics providing \$200 to \$400 million dollars' worth of care annually.

**County health departments:** These clinics are operated through the Georgia Department of Community Health's Division of Public Health, which oversees 159 county health departments in the state. Health departments generally offer a more limited range of services than a federally qualified health clinic, a hospital system clinic or a community clinic. These departments typically provide women's and children's health services, immunization services, and sexually-transmitted disease testing. These clinics operate on a sliding scale basis and accept private insurance.

**Federally qualified health clinics:** FQHCs<sup>xliii</sup> are community-based organizations that provide comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay.

Health Resources and Services Administration supervise FQHCs, which were established to provide comprehensive health services to the medically underserved to reduce the patient load on hospital emergency rooms.

There are a total 143 FQHCs in Georgia, and 37 in the metropolitan area studied. Nine of the counties studied do not have a FQHC.<sup>xliiv</sup>

**Volunteer and community health clinics:** Community health centers generally operate without federal funds, and instead rely on local donations of both time and money. Often, physicians will volunteer their hours to work at these facilities. These facilities operate as not-for-profit entities, and offer free and sliding scale care to eligible patients. These facilities also treat uninsured patients, regardless of their income.

Of the patients served at Georgia's free and reduced-cost volunteer and community health clinics:

- 62 percent lived below the federal poverty level;
- 85 percent were between the ages of 18 and 64;
- 33 percent lived at or up to two times the federal poverty level; and,
- 4 percent lived above twice the federal poverty level.<sup>xlv</sup>

A 2007 Baylor Health Care System study reported a 75 percent reduction in hospital admissions in patients who received ongoing primary care from a charity clinic. The study also showed a 63 percent reduction in the hospital costs of treating these patients.

Hospital-associated clinics: Several clinics in the metropolitan area operate under the umbrella of, or in association with, a hospital. As with community clinics, these facilities generally provide primary care services on a free or sliding scale basis to uninsured and underinsured patients.

Two such examples in the metropolitan Atlanta area are Saint Joseph’s of Atlanta’s Mercy Care Services and the clinics operated under the Grady Health System.

### ***Grady Health System clinics***

Grady Memorial Hospital operates nine clinics as part of its system. But, as Grady Hospital struggles to boost its bottom line, at least two clinics have closed in efforts to rein in costs. In 2009, Grady closed the Center Hill Health Center, which was located in west Atlanta, despite community objection. During that same time, Grady Memorial reported it would shutter its dialysis center. A method of replacing lost kidney function, dialysis is necessary for survival for those who need such help. Without insurance, dialysis treatment costs \$40,000 to \$50,000 annually and at private clinics, who traditionally do not take uninsured or Medicaid patients, the cost of dialysis care can easily surpass \$70,000. Grady reported a \$2 million and \$4 million loss each year in operating the center. The hospital, already struggling as the largest safety net facility in the state, claimed it was unable to afford that loss.

Many advocates strongly protested Grady’s decision to close the dialysis clinic, and a central argument that arose was that of immigrant health. Of the nearly 100 patients the clinic actively treated at the time, about two-thirds were immigrants. While Grady offered to pay for three months of private clinic care or to pay for trips back to their home countries, the closing of its dialysis clinic posed many issues, with the primary challenge of accessing affordable care.

The clinic officially closed in October 2009. About a third of the patients were transferred to other clinics or moved, including several undocumented residents who returned to their native countries with the hospital’s financial help. But others have said they have no place to go, have no means to pay for dialysis or are too ill to travel.<sup>xlvi</sup>

### **The emergency room**

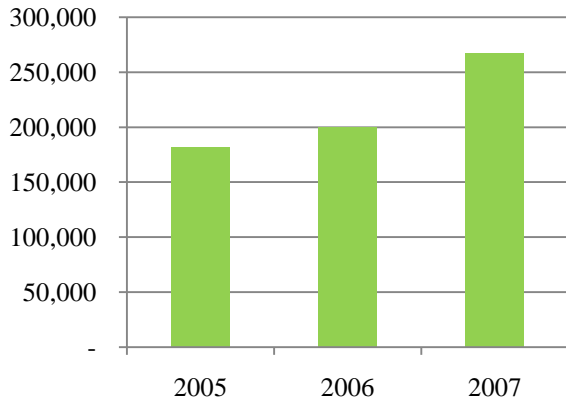
All metropolitan Atlanta acute care facilities operate an emergency room that operates 24 hours a day, seven days a week. Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals participating in the Medicare program are required to stabilize and treat anyone who enters the emergency room, regardless of their insurance status or ability to pay.

Many low-income, uninsured and underinsured individuals use the emergency room as their access point to a hospital and as their primary care provider for two main reasons: first, many uninsured consumers avoid care until a condition escalates to an emergency situation. Second, these consumers believe the emergency room is their only health care option, because is the only place in a hospital where care is guaranteed regardless of the patient’s ability to pay. Those with chronic conditions may be unable to access affordable specialty care, and unable to afford a prescription for necessary drugs, so their condition deteriorates to a point where emergency care is required. Generally however, the patient is discharged from the emergency room when his



or her condition stabilizes and, when the condition again deteriorates, the patient returns to the emergency room seeking urgent care.

### ER visits for self-pay patients in the metro area



Between 2005 and 2007, the number of visits for uninsured and/or self-pay adults visiting the emergency room rose more than 19 percent in Georgia. Some areas of the metropolitan area saw bigger percentage jumps in self-pay/uninsured patients, such as Paulding County, where WellStar Paulding is based, experienced a significant jump in the number of uninsured patients between 2005 and 2007 – from 6,460 in 2005 to 23,118 in 2007. Cherokee County, which is home to Northside Hospital-Cherokee, experienced a similar hike.<sup>xlvi</sup>

The emergency room is the most expensive point of entry at a hospital. Some visits would be better handled in a clinical or primary care setting. For example, it typically costs \$715 to treat a urinary tract infection in an emergency room<sup>xlvi</sup> but a urinary tract infection can be

treated more affordably in a clinic or primary care setting. In Georgia, the average clinic visit is \$29 and an average primary care doctor visit can range from \$75 to \$120. About 37 percent of all emergency room visits in 2007 were during regular business hours, making clinics and urgent care centers viable alternatives to the emergency room when non-emergent care is needed.<sup>xlix</sup>

### Hospital narratives

Each hospital and hospital system encounters its own challenges and/or opportunities when caring for uninsured, underinsured and low-income patients. In recognition of that, all hospitals studied in this report were invited to submit a narrative of their particular issues and communities. Emory Healthcare, Piedmont Healthcare, Saint Joseph’s Hospital of Atlanta and WellStar Health System provided their narratives, as presented below.

#### Emory Healthcare

“Emory Healthcare has been faced with two major challenges, however, due to the current economic environment:

- A. How to become even more efficient in the way Emory Healthcare does business in response to these unprecedented economic events; and,
- B. How to continue to provide the very best level of care to Emory Healthcare’s valued patients – both the insured and the rapidly growing numbers of under- and uninsured.

“In response to the first challenge of operating a health care system as efficiently and successfully as possible, with little to no loss of employment to our own staff, Emory Healthcare sought input from our employees and engaged them to team with us in identifying cost-saving programs. These ideas saved Emory Healthcare millions of dollars without sacrificing quality health care services and treatment for all patients, and allowed us to continue to provide this same level of services and treatment.

“In response to the second challenge of caring for our community during this unprecedented time, Emory Healthcare provided approximately \$49 million in charity care in FY2008-2009, including almost \$34 million just at Emory University Hospital and Emory University Hospital Midtown alone,

including care to indigents and catastrophic care for patients with some coverage but with expenses that would far exceed their coverage.

“Emory Healthcare, as the largest, most comprehensive health care system in Georgia, understands the role and impact we provide, and that it is our mission and obligation as an academic health center, responsible community partner, and employer to serve those in their hour of need.”

*- Robert Bachman, COO, Emory University Hospital*

### **Piedmont Healthcare**

“Piedmont Healthcare is a not-for-profit system that includes Piedmont Hospital in Buckhead, Piedmont Newnan Hospital, Piedmont Fayette Hospital, and Piedmont Mountainside Hospital in Jasper. While our mission is the same, our communities are all distinctly different and, as such, our hospitals provide services tailored to the individual needs of those communities.

“As reflected in this report, while Piedmont Mountainside Hospital is located in an area with the highest level of uninsured patients, Piedmont Hospital in Buckhead has less. In 2008, two of our hospitals lost money in providing care, while two were able to exceed operating costs. We are thereby able to keep the doors of these facilities open by offsetting the losses and enabling them to provide the highest quality of care and community services for our patients and communities. We are indeed better together than any one of our entities would be alone.

“I am most proud of our investment in quality initiatives, placing Piedmont among the highest quality provider systems not only in greater Atlanta, but in Georgia and throughout the country. For the past three years, our expected death rates are among the lowest in hospitals across the country. We also experience a lower rate of hospital-acquired infections; this data as well as other quality indicators are posted on our web sites.

“In 2008, we provided \$122.5 million (cost of care, not charges) in community health services, charity and indigent care, bad debt and shortfalls in Medicare and Medicaid funding. We have also sought partnerships with organizations such as Good Samaritan Health Center, Grant Park Clinic, Fayette Care Clinic and City of Refuge that improve access to care for those who are uninsured or underinsured. In Coweta County, Piedmont Newnan Hospital is facilitating development of such a clinic to serve area residents.

“Piedmont’s partnership with Mercer University addresses the critical shortage of health care workers, resulting in new nurses and physician assistants each year. This effort will serve to expand access to care for Georgians as well. This \$5 million investment (over the past three years) does not include the time of our medical and professional staff members spent growing the knowledge base of future health care providers.

“Although Piedmont is a not-for-profit system, we financially contribute to our communities and the state economy by paying \$34 million annually in employment, property and sales taxes and by employing more than 8,000 people who, in turn, make purchases and pay taxes. When applying the economic output multiplier, Piedmont Healthcare as a system contributes nearly \$2 billion each year to the economies of our communities, cities and state.

“It is both a privilege and a responsibility to serve residents of Georgia in a time of need, regardless of ability to pay.”

- R. Timothy Stack, President and CEO, Piedmont Healthcare

### **Saint Joseph’s Hospital of Atlanta**

“Saint Joseph's Hospital of Atlanta is a 410-bed specialty hospital that offers a broad range of services from primary through tertiary care, and serves both inpatients and outpatients with the highest standards of quality regardless of their ability to pay. As a tertiary care provider, Saint Joseph’s delivers services to metropolitan Atlanta and surrounding communities with an exceptional medical and clinical staff and technical leadership that has resulted in numerous national distinctions including recognition by HealthGrades as a top 50 hospital and the Magnet designation for nursing excellence.

“In addition to the reputation that Saint Joseph’s has built for providing high quality care, there is also a strong commitment to serving all patients that is reflected in Saint Joseph’s participation in Medicaid, provision of significant levels of uncompensated charity and indigent care, offering of options for patients that are facing catastrophic medical procedures or need to pay for services on an installment basis, and provision of significant discounts (>50 percent) to all patients presenting without insurance. Although Saint Joseph’s Medicaid services are a small percent of its patients, it is reasonable when one considers that Saint Joseph’s does not provide obstetrics or pediatric care, the two greatest populations of patients with Medicaid coverage.

“At the heart of Saint Joseph’s Health System though, is Saint Joseph’s Mercy Care Services, which is one of Atlanta’s oldest and largest community outreach programs serving the homeless, uninsured, and immigrant populations in Atlanta. Created in 1985, Mercy Care is a system of primary health care and social services for Atlanta’s least served that was established to continue the community outreach in downtown Atlanta begun by the Sisters of Mercy in 1880 when they opened Saint Joseph’s Hospital, Atlanta’s first permanent hospital. With more than four fixed locations across downtown, six clinics located in community partner’s facilities, and mobile units across Atlanta, Mercy Care has become the medical home for thousands who would not otherwise have care, including AIDs sufferers and homeless. As of 2008, Mercy Care had significant recent growth, nearly 20 percent over the past three years, in the outpouring of care to those who need it most; 30,272 patient visits to the medical and dental programs resulted in 9,995 people receiving medical and dental care, including 358 pro bono medical assessments and procedures. Mercy Care also became the primary medical care partner for the 24/7 Gateway Homeless Services, a project of the Atlanta Regional Commission on Homelessness, and established a 19-bed recuperative care unit to provide a place for homeless patients to recover once they are ready to be discharged from inpatient care providers such as Grady Memorial Hospital.

“Mercy Care is a unique and generous program that provides a robust medical service offering and cares for patients holistically by providing social services and health education through its clinics and mobile units, as well as residential support services at two downtown facilities. Funding for Mercy Care comes from Saint Joseph’s Hospital which annually provides an average of \$1.5 million in monetary support to Saint Joseph’s Mercy Care Services. Other sources of funding to provide these medical and dental outreach services to the Atlanta community come from federal, state and city grants, corporations, foundations, individuals, Saint Joseph’s Health System and the WINGS organization of Saint Joseph’s Mercy Foundation.”

- Kirk Wilson, CEO, Saint Joseph’s Hospital of Atlanta

## **WellStar Health System**

“As the largest not-for-profit health system in Georgia, WellStar Health System is committed to serving the health care needs of the community. With five hospitals, 400+ physicians and advanced practitioners, a multi-specialty physicians group and more than 11,000 team members, we remain dedicated to ensuring our patients get well, stay well and live well.

“Like many hospitals, over the last several years WellStar has experienced a rising number of uninsured and underinsured patients. At the same time, Medicaid and Medicare reimbursement rates have remained below the cost of providing services. In FY2009, WellStar incurred expenses nearing \$40 million (in cost) for indigent and charity care services and \$57 million (in cost) for other uncompensated care services. In addition, WellStar facilities and physicians were paid \$32 million less than the cost of care for Medicaid patients and \$54 million less than the cost of care for Medicare patients. Combined, this equates to \$183 million in the cost of care that was not reimbursed.

“While the financial losses on uninsured, Medicaid and Medicare patients are significant, WellStar is driven by our mission to serve the health needs of all patients, regardless of their ability to pay. Through education and communication, patients are offered the opportunity to utilize resources that may help manage the financial responsibility for their health care. In addition, through the discharge process, efforts are made to assist patients in planning for their future health care needs through WellStar clinics and other community resources.”

*- Dr. Gregory Simone, CEO, WellStar Hospital System*

## **Access and affordability**

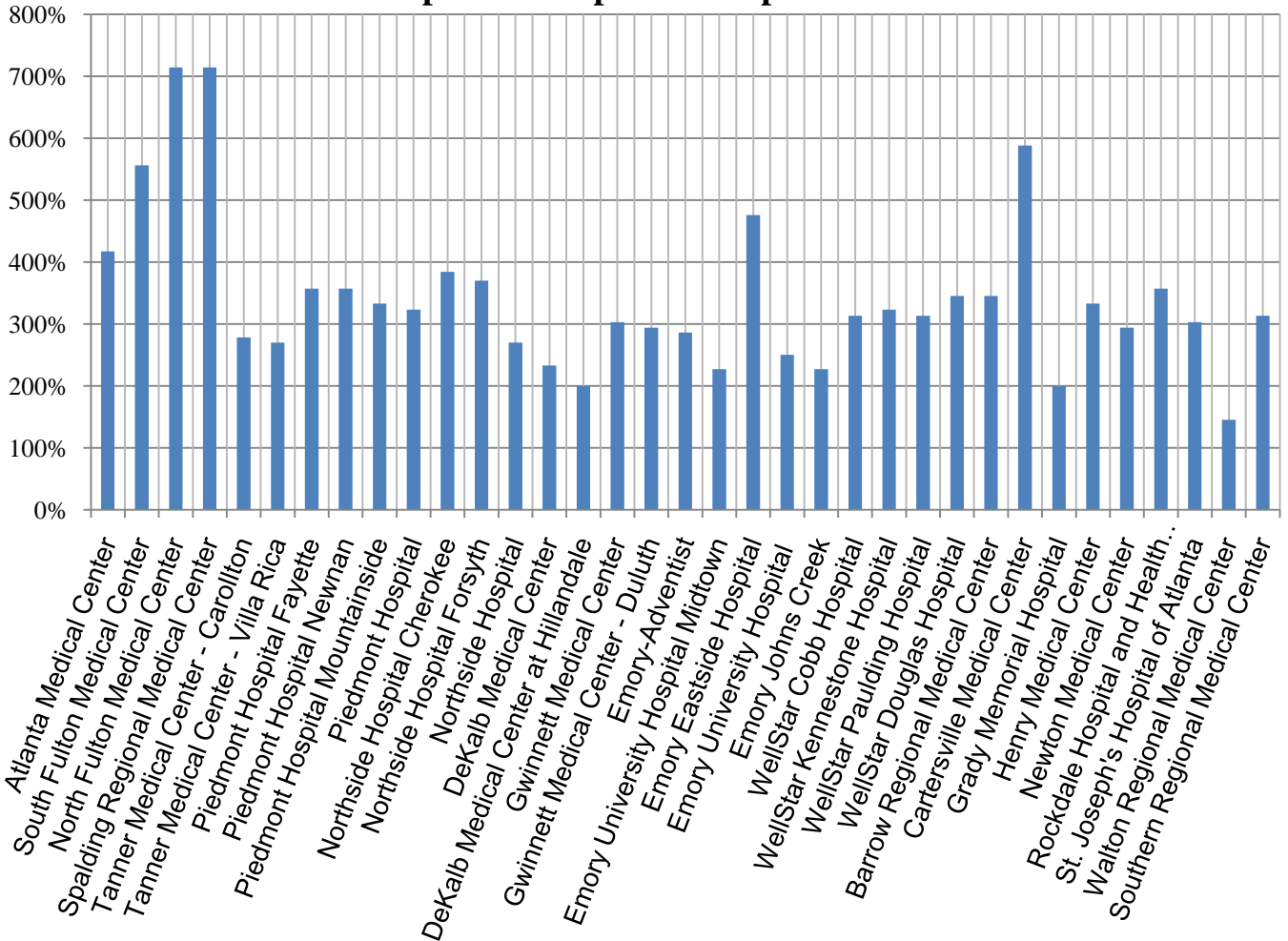
The cost of care is directly related to the patient’s ability to access health services, and controlling hospital charges is central to lowering overall health costs.<sup>l</sup> Many metropolitan Atlanta hospitals charge more for their services than the actual cost of the services, which likely forces many patients to delay or avoid care based on financial reasons.

### ***Pricing and mark-ups***

At metropolitan hospitals in 2008, for every \$1.00 the patient was charged, the hospital incurred an average cost of \$0.33.<sup>li</sup> The disparity between actual costs and amount charged may be estimated by using the hospital’s cost to charge ratios as reported to DCH. In 2008, the five most expensive hospitals in the metropolitan area were, in order of highest to lowest, North Fulton Medical Center, Cartersville Medical Center, South Fulton Medical Center, Emory Eastside Hospital and Atlanta Medical Center. All are for-profit entities.

That year, the five least expensive hospitals in the metropolitan area were, in order of lowest to highest, Walton Regional Medical Center, Grady Memorial Hospital, Emory University Hospital Midtown, Emory Johns Creek and Emory University Hospital. Interestingly, the two facilities with the lowest mark-ups also offer the highest amount of uncompensated care.

## Mark-ups at metropolitan hospitals in 2008



Hospital representatives and industry professionals defend the difference between what a patient is charged versus what the service or product actually costs as a means to offset the cost of providing unreimbursed care for low-income, uninsured or underinsured patients who do not qualify for financial assistance and are unable to pay their bills.

Generally speaking, even when hospitals provide a discount, the difference between the actual cost and the amount charged is significant. For example, a self-pay patient receives a hospital bill for \$3,500 for services that cost the hospital \$1,060. The patient is eligible for a 20 percent discount (about \$700) so the patient owes the hospital \$2,800, which is about 2.6 times what it cost the hospital to provide the service.

### Quality

Lower cost does not necessarily mean there will be a lower quality of care. According to recent studies, there is no consistent relationship between the cost of hospital care and the quality of that care for two common diagnoses: congestive heart failure and pneumonia.<sup>lii</sup> A comparison of coronary artery bypass graft surgery performed in the US versus Canada showed substantially higher costs in the US but similar outcomes in both countries.<sup>liii</sup> Also, a recent study of Medicare recipients who had suffered a myocardial infarction also found that increase in hospital costs were not associated with improvements in survival.<sup>liiv</sup>

## **Compelling hospitals to provide financial assistance**

All hospitals in the metropolitan area offer some sort of financial assistance through the ICTF, Certificate of Need (CON) obligations or their own founding mission.

### **Community benefits**

Community benefits are programs offered to the community as an informal exchange for a nonprofit hospital's tax-exempt status. These programs are meant to boost the health of the community it serves, especially that of its more vulnerable populations. Because they receive formidable tax breaks, nonprofit hospitals are charged with addressing the health needs of its community. Those tax breaks are meant to spur the not-for-profit hospital to go above and beyond its for-profit counterpart in its offerings to the local community as a way to justify its not-for-profit status.

Many facilities interpret this obligation solely as uncompensated care but they should also consider community benefit programs. Community benefit programs can reduce the cost of uncompensated care for hospitals by improving the health of the community through cancer screenings, health education and other such services that target uninsured and underinsured populations Georgia does not require not-for-profit hospitals to meet a minimum standard of community benefits in exchange for these tax-exempt breaks, nor does it require a not-for-profit facility to provide information on those benefits beyond basic reporting of its indigent and charity care expenditures. Some hospitals do, however, provide ample information on their community benefit programs.

For example, in their 2008 IRS Form 990, Gwinnett Medical Center and Piedmont Healthcare both had comprehensive, easy to quantify community benefit reporting. Both hospitals included community benefit programs in their strategic planning and had dedicated reports to report and evaluate their services. WellStar Health System and DeKalb Medical Center were both thorough in their reporting on the IRS Form 990 that same year. Southern Regional Hospital included a short paragraph of community benefit provision, but information provided was limited.

Other hospitals provide little information as to the services they provide in exchange for their tax-exempt status. Both Henry Medical Center and Rockdale Medical Center provided no community benefit reporting outside of uncompensated costs and Medicaid shortfalls. Moving forward, Rockdale Medical Center will have no official obligation to report this information, as it is now a for-profit entity, and is not bound to the same obligations as not-for-profits.

### ***Going beyond indigent and charity care***

Community benefits do not just include free or subsidized care for qualifying patients. Through clinic support, health screenings and appropriate follow-up care, and other such benefits, health conditions can be more affordably treated in setting outside the emergency room, and conditions with a potential for high fiscal and physical impact will have more swift action, therefore staving off pricey hospital care.

Common examples of these community benefit programs include mobile mammography units in low-income neighborhoods, such as that provided by DeKalb Medical Center, or the recent partnership forged between Emory Healthcare and the DeKalb County Solicitor's office partnership to provide medical assistance for abused seniors. At the very least, all community benefit programs should, to some degree, address a community need, improve access to health services, enhance the health of its community, advance the health knowledge of its community and/or demonstrate the hospital's charitable purpose.

### ***Calculating the value of a hospital's tax-exempt status***

There are four primary taxes nonprofit hospitals generally do not pay: property taxes, state and local income taxes, sales tax and bond financing. Property taxes comprise the largest amount of a facility's tax exemption

– about one-quarter. Local tax assessors do not annually evaluate the worth of a hospital’s property, and hospitals generally do not provide to its local and state government an estimation of the value of the income, bond financing and sales tax exemption.

In the absence of this transparency and stewardship, county and state authorities are able to calculate these values without the hospital’s input through a series of mathematical equations, though these equations will only provide a ballpark figure. Regardless, even having a baseline to calculate the worth of these exemptions is a first step towards the assurance that the community is indeed getting its value for those foregone taxes, as well as the equalization between nonprofit hospitals in regards to the amount of care and the strength of the programs aimed at boosting the health of low-income and uninsured populations. As referenced elsewhere in this report, not all nonprofit hospitals provide to their community the same level of community benefits, which can, in turn, force another hospital to carry the burden of care for those who need assistance.

### **CON requirements**

Through Georgia’s Certificate of Need (CON) program,<sup>lv</sup> hospitals with an active CON are required to provide a set percentage of their annual adjusted gross revenue (AGR) as uncompensated care to eligible patients – generally between 3 percent and 3.5 percent. Appendix C provides detailed information on each hospital’s CON obligations and what the hospital actually provided in terms of uncompensated care.

Many hospitals went far above their basic required amount of indigent and charity care, such as Piedmont Mountanside Hospital, Southern Regional Medical Center and Walton Regional Medical Center. Several hospitals – Grady Memorial Hospital, Spalding Regional Hospital Cartersville Medical Center, Emory-Adventist and WellStar Paulding – had no obligations to provide uncompensated indigent and charity care, yet still rendered high percentages, as did Emory University Hospital and Emory University Hospital Midtown.

Some facilities barely met the required amount of uncompensated care, including Saint Joseph’s Hospital of Atlanta, Emory Johns Creek Hospital and Piedmont Hospital. North Fulton Regional Medical Center did not meet the required minimum amount of uncompensated indigent and charity care.

In March 2010, the Georgia Department of Community Health issued a CON to Newton Medical Center for a \$1.75 million da Vinci surgical system. Nearby Rockdale Medical Center also recently applied for a CON for the surgical system, which 21 other hospitals in the state have or will soon purchase per approved CON applications. The hospital already holds a CON, which obligated them to \$4.27 million in indigent and charity care in 2008.

### **House Bill 307**

Legislation passed during the 2010 Georgia General Assembly that required hospitals to pay a provider fee of approximately 1.45 percent<sup>lvi</sup> of its net patient revenue.<sup>lviii</sup> This money will go to the state’s Indigent Care Trust Fund (ICTF), which will then be dispersed to hospitals per standard ICTF protocol. This bill benefits most the hospitals that provide the highest amount of uncompensated care to low-income individuals. This is a temporary infusion of cash; the bill expires in three years.

Among the metropolitan Atlanta hospitals most affected by this bill will be Grady Memorial Hospital, South Fulton Medical Center, Atlanta Medical Center and DeKalb Medical Center, all of which are projected to receive funds from the disbursement as they care for high numbers of Medicaid patients. Piedmont Hospital, Northside Hospital, Emory University Hospital, WellStar Kennestone Hospital, Emory Eastside Medical Center and Emory University Hospital Midtown are also among the most affected, though they will suffer the most significant net loss.

An eleventh-hour amendment to the bill allows for the fee a hospital pays to be applied to its CON obligations for uncompensated care. In most scenarios, this payment will far exceed what hospitals are

obligated to provide in uncompensated care, prompting concerns by some that these care offerings at hospitals, especially those who already provide low levels of Medicaid and indigent care, will diminish, as that minimum level will no longer be necessary due the direct payment to the state to the ICTF.

### **Indigent Care Trust Fund**

Most tax-exempt hospitals in Georgia receive funds from the ICTF, a 20-year-old program that expands Medicaid eligibility and services, supports rural health care facilities that serve the medically indigent, and funds primary health care programs for medically indigent Georgians. Georgia's Disproportionate Share Hospital (DSH) program is funded through the ICTF, which provides funding to hospitals and other health care providers to help offset financial losses on uninsured, underinsured and low-income individuals, as defined by the state plan in accordance with federal regulations.

DSH payments are additional payments in Medicaid and Medicare programs that help finance care to low-income and uninsured patients. These payments also help ensure that certain high-cost services – such as burn units and trauma care – are available to everyone. Such patients were believed to incur higher-than-average costs, so hospitals that served many of these patients would likely encounter greater costs for their Medicare patients than would other facilities. These hospitals often have higher uncompensated care costs and fewer patients with private insurance than other hospitals.

Approximately 145 private and public hospitals participated in Georgia's DSH program. Hospitals included both rural and urban facilities.

In exchange for receiving that money, participating hospitals must:

- Keep a log of eligible patient accounts, with relevant patient financial information, including billing information;
- Ensure that preadmission deposits are not required on demand as a condition of treatment of Medicaid eligible persons or medically indigent persons; and,
- Maintain clear signage in points of entry to the hospital that financial assistance is available for those who qualify, and are given written information explaining the terms of eligibility and the application process for those services.

By complying with these regulations, hospitals are better able to serve their financially vulnerable patients. At least one hospital studied asks that uninsured patients provide a \$2,000 deposit upon entry to the hospital, but it is unclear whether this applies to all patients, or only patients deemed ineligible for financial assistance.

### **Financial assistance offerings at hospitals**

All metropolitan Atlanta hospitals offer some sort of financial assistance to eligible patients.

#### ***Eligibility requirements***

Financial assistance eligibility requirements vary from hospital to hospital though all, to some degree, utilize income figures to determine if a patient qualifies for assistance. The ICTF establishes minimum standards that require the hospital to provide free services to persons with incomes below 125 percent of the federal poverty level and to provide free services or adopt a sliding fee scale for persons with incomes between 125 and, at a minimum, 200 percent of the federal poverty level.



The ICTF manual also sets out standards for determining patient eligibility:

- Income should be considered the family's gross income, either determined by the average monthly income for the previous three months or for the previous year, whichever is more favorable to the applicant;
- For those who are self-employed, income counted is gross income minus work expenses directly related to producing the goods or services, and without which the goods or services could not be produced;
- Temporary Assistance for Needy Families (TANF) or Social Security Insurance income should not be counted; and,
- Income from any person who is not financially responsible for the patient should not be included, such as child support payments.

In addition, some hospitals offer financial assistance only to residents of the county in which it is located, such as Southern Regional Medical Center, who offers financial assistance only to residents of Clayton County.

Under ICTF guidelines, hospitals are required to provide to the general public with a copy of their formal financial assistance policies. During the site visits conducted at the 34 surveyed hospitals in April 2010, almost every hospital representative stated that a patient's eligibility would be determined on a case-by-case basis and that standard guidelines were not available. When pressed, some hospitals verbally provided income eligibility levels.

Hospitals participating in the ICTF are required to provide a copy of their financial assistance policy, and the failure to do so is not just a violation of regulation but also a barrier to affordable care for many patients. While counseling of available financial assistance is given at most hospitals upon discharge, the lack of a hospital's policy in a written, clear and transparent manner that is available upon request is a disturbing trend among metropolitan Atlanta hospitals.

### ***The use of financial data to determine ability to pay***

Many hospitals now use patient classification software that utilize credit information to identify patients who qualify for charity or free care, those eligible for discounts and those who should pay his or her hospital bill.<sup>lviii</sup> At some hospitals, this software is used only for self-pay patients who have not completed a charity care application. Other hospitals use this service to instantly determine the patient's ability to pay after a patient submits his or her information.

For example, Emory Healthcare utilizes *SearchAmerica*, which utilizes patient information to assess eligibility for assistance, allowing for immediate assistance determination once a patient has submitted the necessary paperwork. *SearchAmerica* is owned by credit reporting agency Experian, and utilizes credit information and other data sources.

Proponents of this and other similar systems claim that identifying those who are eligible for financial assistance and/or government programs such as Medicaid, is a better process for evaluating a patient's ability to pay, therefore reducing a hospital's bad debt and bettering their collection practices.

Critics of this approach to health care billing question the use of credit scoring to determine eligibility for discounted health care because a patient's credit score could be high even if income is low. The use by hospitals of credit scoring can be slippery slope towards more aggressive bill collection practices for those who may appear, on paper, to be able to afford their hospital bill but, in reality, are not. Many hospitals do not use actual credit scores to determine a patient's ability to pay; instead they use information contained within a patient's credit file and other available public information to determine a patient's ability to pay.

### ***Applying for care***

All hospitals have a financial assistance application that requests income and expense information. Supporting documentation is generally required, such as income verification through pay stubs and employer statements. The applicant's statement of zero income may also be accepted, though a notarized letter may be required. Hospitals may also ask for income tax returns, bank statements and leases or mortgage statements.

### ***Duration of approval***

Most hospitals ask patients to apply for financial assistance for each stay or treatment at their facility. At Grady Memorial Hospital, patients are required to reapply for financial assistance every 30 days. Other hospitals have financial assistance determination periods that last for as long as 180 days.

### ***Appealing a denial of financial assistance***

Patients have the right to request the hospital to re-evaluate a denied financial assistance application. If the hospital upholds its denial, patients have the right to ask the Georgia's DCH to approve their application if the hospital participates in.

## **Comparing hospitals**

A general benchmark for evaluating how much uncompensated financial assistance a hospital provides is to calculate those offerings as a percentage of their adjusted gross revenue.<sup>lix</sup> The below chart reflects *charges* not *cost*, and percentages may appear higher for hospitals that have high mark-ups.

The hospitals that provided the highest percentages of indigent and charity care in 2008 are, in order: Grady Memorial Hospital, Barrow Regional Medical Center, Emory-Adventist Hospital and Piedmont Mountainside Hospital.

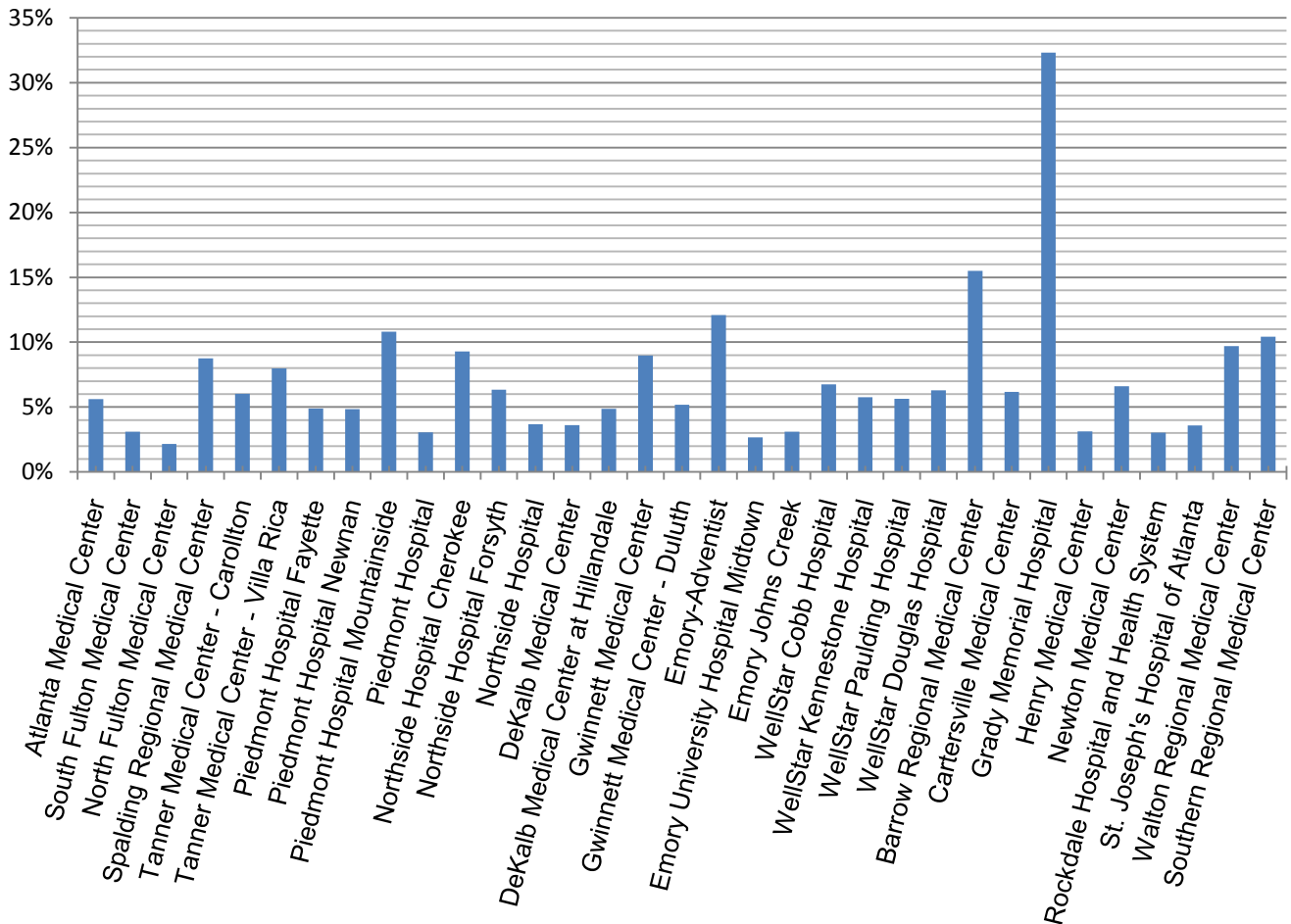
The hospitals with the lowest percentages of indigent and charity care in 2008 are, in order: Piedmont Hospital, North Fulton Medical Center, Emory University Hospital Midtown and Rockdale Hospital and Health System.

Overall, hospitals examined in this study provided an average 6.5 percent of their annual adjusted gross revenue in uncompensated indigent or charity care charges in 2008. Not-for-profit and authority-owned facilities provided a higher average of uncompensated indigent and charity care than their for-profit counterparts — 6.99 percent versus 4.20 percent, respectively. The 34 hospitals studied in the metropolitan Atlanta area provided a combined \$881,245,118 in uncompensated indigent and charity care in 2008.

But, as this amount is reported at charge – not cost – to the Department of Community Health, a more accurate amount of uncompensated care for all hospitals in 2008 is about \$293.7 million, once the cost-to-charge ratio is applied. With a combined annual adjusted gross revenue of \$13.5 billion of all hospitals studied in the report, the amount of *at cost* uncompensated indigent and charity care was only about 2.17 percent, versus the 6.5 percentage that results when full charge is calculated.

Specifically, by ownership, for-profit hospitals provided a lower percentage of its AGR as at cost uncompensated indigent and charity care – an average 0.92 percent. Not-for-profit hospitals averaged significantly higher at 2.51 percent, though this is still a relatively small amount of a hospital's total adjusted gross revenue.

## Uncompensated indigent and charity care provided at metro hospitals, as a percentage of the hospital's AGR



*Note: Information regarding Emory Eastside Hospital and Emory University Hospital was not available.*

Some hospitals provided much higher levels of uncompensated indigent and charity care, calculated at cost, than others. For example, Northside Hospital provided only 1.37 percent of its AGR as uncompensated care, as opposed to Grady Memorial, which provided 16.1 percent. As noted before, both are county authority-owned facilities

Grady Memorial Hospital is generally known as the “go-to” facility for those without health coverage. The hospital has held this distinction for decades, despite being one of ten hospitals within Fulton County, where it is located. Collectively, those other hospitals provided \$125,455,348 in uncompensated care charges, far less than half of the \$293,547,705 in uncompensated care charges Grady Memorial provided that same year. In addition, the DeKalb County-based Emory Healthcare reported \$23.1 million in uncompensated care provided by Emory physicians at Grady Health System.

This sort of uneven burden can cause financial stress that could lead to the hospital’s closure, and in the past several years, Grady Memorial has struggled to survive due to the debt incurred by serving a high volume of low-income and uninsured patients, and has undergone organizational and leadership changes in efforts to survive.<sup>lx</sup>

## Notifying patients

As stated above, hospitals participating in the ICTF are required to notify patients of the availability of available financial assistance.

### *On-site notification*

In addition to the display of information in various areas, the hospital must provide forms and instructions to those who may be eligible for reduced or free care.

Specifically, ICTF regulation requires that hospitals must:

- Provide notice of available financial assistance that must include the following:
  - The availability of free and reduced-charge services;
  - The patient's ability to gain admittance without pre-admission deposits;
  - The right not to be transferred solely or insignificant part for economic reasons;
  - The availability of services provided;
  - The terms of eligibility for free and reduced-charge services;
  - The application process for these services; and,
  - The person or office to which complaints or questions about the hospital's participation in these services should be directed.
- Provide similar individual notices to each patient potentially eligible for free or reduced-charge services. These notices should also be included with a patient's bill, and should include the Department of Community Health's toll-free number for individuals to call if they are unable to resolve any problems experience with ICTF assistance at their hospital.
- Place easily readable signs in the emergency room, business office and the admissions area that include the appropriate program information.
- Provide notices in English, Spanish and any other appropriate languages.
- Instruct staff to communicate the content of the notices to people who are unable to read and to assist individuals who have difficulty applying for available services.

Of the 34 hospitals visited in April, only 17 had signs advertising the availability of free or reduced-cost care in the emergency room and/or cashiers area. These signs were almost always only at the cashiers desk or in the financial assistance office, and often did not include information on how to appeal a denial.

Northside Hospital, Emory Adventist Hospital, all WellStar facilities, all Tenet Hospitals, Emory University Hospital, Emory University Hospital Midtown, Walton Regional Hospital and Saint Joseph's Hospitals all had signage indicating financial assistance was available. Notably, when a project surveyor visited their facilities, both Walton Regional Medical Center and South Fulton Medical Center both excelled at their helpfulness in providing any needed information, as did Emory Adventist, of which a representative fully explained their assistance policy, though did not inform the patient of available financial assistance

All Piedmont Hospitals, both Gwinnett hospitals, both DeKalb Medical Centers, both Tanner Health System hospitals, Southern Regional Medical Center, Henry Medical Center, Northside-Cherokee Hospital, Northside-Forsyth Hospital and Barrow Regional Hospital did not have signs posted that indicated financial assistance was available, though a few of these hospitals did post patient rights. Though they did not have signage advertising the availability of financial assistance, DeKalb Medical Center, Henry Medical Center and Northside Hospital-Forsyth representatives helpfully provided detailed information about their policies, procedures and requirements.

See Appendix B for a list of hospitals and signage.

### ***Online notification***

Some hospitals provide clear and easy-to-access information about its financial assistance program on its website, such as the four hospitals of Piedmont Healthcare, which detail the eligibility requirements and financial thresholds for assistance. Saint Joseph's Hospital of Atlanta also provides information on its policies, as do the hospitals within Tenet Healthcare, which also provides financial information in Spanish. Both Gwinnett Medical Center facilities, Rockdale Medical Center, Newton Medical Center, WellStar Health System and Henry Medical Center provided financial assistance, with the latter giving detailed information on its policy.

Several hospitals use an external site to provide both financial assistance and pricing information, including all Northside hospitals, though the link to that external site was somewhat difficult to find. Emory Eastside uses this same site, as does Cartersville Medical Center, Emory Johns Creek. Others do not, such as Emory University Medical Center, Emory University Hospital Midtown, Walton Regional Medical Center and Southern Regional Medical Center.

It is important to note that not all consumers have web access, especially low-income individuals, as internet access is directly correlated with a household's combined annual income, as well as their education level.<sup>lxi</sup> In addition, internet access is lowest in Hispanic and African-American households, and the former of which is already at a disadvantage as so few hospitals provide information on their sites in Spanish.

### **Consumer obligations**

Just as hospitals have obligations to their patients, consumers too have obligations in ensuring their care is appropriate and affordable.

#### ***Seeking appropriate care***

In non-emergent situations, low-income, uninsured and underinsured consumers should seek out affordable options to care, such as those provided by a local clinic. By doing so, he or she is more likely to afford his or her bill, and less likely to develop an urgent health care need that may require use of the emergency room.

#### ***Accessing financial assistance***

If a consumer enters the hospital, her or she should always immediately inquire about financial assistance programs, and ask to apply if there is a chance they may qualify for help. Upon receiving an application, he or she should make sure to submit all the requested information to qualify for care. Failure to do so will often result in a rejected application. If the consumer is unsure of how to obtain certain documentation, such as income verification, he or she should ask the financial aid officer for guidance.

All patients should ask for an itemized bill to confirm charges are correct. If any charges or information on the bill is unclear, the patient should request that a financial officer review and explain the bill. Patients should provide the hospital with the requested information and documentation as soon as possible, and should seek assistance from a financial counselor if they do not have certain documentation or are unsure as to where to locate a particular item.

Many doctors and clinicians encountered by a hospital patient are independent contractors, and are therefore not bound to any financial arrangements the hospital may provide. Negotiations will need to be made with those individual providers, if possible. The simplest way for patients to know if a person will be part of their treatment is to ask detailed questions about their care. For example, if a patient is to undergo surgery, he or she should ask the hospital's financial officer if anesthesia services will be part of the overall hospital bill, or if they are using a separate contractor for that service. A patient can also ask to be notified if they are to receive care or services from someone not affiliated with the hospital, and that would bill the patient

separately. Due to the complex method of care delivery at hospitals, this sort of notification may be difficult to obtain but it is the patient's right to ask.

### *Negotiating their bill*

If the consumer does not qualify for financial assistance, he or she should negotiate with the hospital for a discount, particularly those patients who might be able to pay a discounted bill. Many hospitals will grant a self-pay discount, which can be as high as 25 percent at some facilities.

If the patient is unable to pay the bill in full even with a discount, he or she should set-up an affordable payment plan with the hospital, and adhere to that agreement.

A consumer must not ignore his or her bill, because it will likely end up in collections or a lawsuit, which limits his or her options. If his or her bill ends up in collections, the patient should ask the debt collector to verify the debt and make sure the delinquent amount claimed is correct and reflects any arrangements made between the hospital and the patient, including any negotiated discounts.

## **Conclusion**

Metropolitan Atlanta hospitals have an opportunity to address the barriers to affordable care that confront uninsured, underinsured and low-income consumers, and to work within their facility and the community to enact policies and create programs that will better the fiscal and physical health of their hospitals and patients.

### *Organizational policy recommendations*

**Compliance with existing laws:** Hospitals should ensure they act in accordance with existing regulations to best serve their patients and themselves.

**Education on staff of financial assistance programs:** Hospital staff that work with patient accounts should be made familiar with policies, laws and obligations the hospital has to the patient. Hospitals should also ensure that staff who may greet a patient – such as those at an information desk – should know where a patient may go to receive information on the hospital's financial assistance policy.

**Appropriate financial counseling:** Patients should receive appropriate financial counseling that is conducted in a one-on-one manner that ensures their information is kept confidential, and therefore does not violate both HIPAA and basic privacy rights. Patients should not be forced to discuss their financial situation at a cashier's window or through other such partitions, as information could easily be overheard, and may act as a deterrent to a patient inquiring about assistance.

**Availability of written financial assistance policy:** A written copy of the hospital's financial assistance policy and income guidelines must be made available upon request, per ICTF obligations. The policy must include income eligibility thresholds and other pertinent information about the hospital's financial assistance policy. This information should be written in clear and easy-to-understand language, and should be provided in the appropriate languages for the populations the hospital serves.

**Signage indicating the availability of financial assistance:** Hospitals should ensure signage indicating the availability of financial assistance is placed at key areas throughout the hospital – the admissions desk, the emergency room, the financial office and the cashier's desk.

**Fair patient billing:** Patient charges should be fair and clearly explained at the time of hospital admission, and this information should be made available to patients in the language that they may easily understand. Collection policies and practices should be fair, and all efforts to avoid collection procedures should be made

by the hospital. Hospitals may not pursue actions for non-payment of a hospital bill against an uninsured patient if that patient has shown that lacks income and assets to meet his or her financial obligations and has provided relevant and necessary information.

### *Legislative policy recommendations*

**Community benefits:** Every not-for-profit hospital should be required to make available to public detailed information on its community benefit programs on its Web site and at the facility. In addition, this information should also be filed with the appropriate governing board, and the hospital should be made accountable to that filing. Every not-for-profit hospital should be required to form a community benefits advisory board that is comprised of community representatives spanning socioeconomic statuses and industry sectors so the determination of what the community needs is fair and accurate. In addition, there should be a statewide standard on what qualifies as a community benefit.

**Oversight:** Increased oversight of state and federal patient financial assistance programs is crucial to ensure compliance with existing laws, including those laws specific for hospitals participating in ICTF and CON programs. Stricter enforcement of these laws is necessary to help protect the state's health care consumers.

Georgia's Department of Community Health should conduct regular audits of filings made by hospitals to the Annual Financial Survey, as well as audits of reported indigent care expenditures for hospitals participating in the Indigent Care Trust Fund program. In addition, hospitals are required to produce annually to the state a log of eligible patient accounts, as established through the Georgia Department of Community Health's Part II Policy and Procedures for Hospital Services.

All hospitals utilizing state and federal funds for charity and indigent care are required by law to have clear signage in points of entry to the hospital that financial assistance is available for those who qualify, and are given written information explaining the terms of eligibility and the application process for those these services. Regular audits of the availability of this information must be conducted in order to assure hospital compliance.

**Compliance:** All hospitals utilizing taxpayer funds for charity and indigent care should comply with related state regulations and requirements. State agencies should establish and enforce penalties for noncompliance.

**Assessments to evaluate the real value of tax-exempt status:** County taxing authorities should annually assess the property holdings of tax-exempt not-for-profit health care facilities to ensure the community is receiving a comparable benefit for the loss of its property tax revenue.

## APPENDIX A: Hospitals studied

Hospitals examined in the report were: Tenet Healthcare (Atlanta Medical Center, South Fulton Regional Medical Center, North Fulton Medical Center and Spalding Regional Medical Center), Tanner Health System (Tanner Medical Center – Carrollton and Tanner Medical Center – Villa Rica), Piedmont Healthcare (Piedmont Hospital, Piedmont Hospital Fayette, Piedmont Hospital Newnan and Piedmont Mountainside Hospital), Northside Health System (Northside Hospital, Northside Hospital – Cherokee and Northside Hospital – Forsyth), DeKalb Medical Center (main facility and DeKalb Medical Center – Hillandale), Gwinnett Health System (Gwinnett Medical Center main facility and Gwinnett Medical Center – Duluth), Emory Health System (Emory-Adventist Hospital, Emory University Hospital Midtown, Emory Eastside, Emory University Hospital and Emory Johns Creek), WellStar Health System (WellStar Cobb Hospital, WellStar Kennestone Hospital, WellStar Paulding Hospital, WellStar Douglas Hospital and WellStar Windy Hill Hospital), Barrow Regional Medical Center, Cartersville Medical Center, Grady Memorial Hospital, Henry Medical Center, Newton Medical Center, Rockdale Hospital and Health System, Saint Joseph’s Hospital of Atlanta, Southern Regional Hospital and Walton Regional Medical Center.

## APPENDIX B: Comparison of on-site signage

The below chart provides a comparison of notification of available financial assistance for patients at hospitals throughout the metropolitan Atlanta area.

Hospital	Is there clear signage at the hospital indicating financial assistance is available?
Atlanta Medical Center	Yes
South Fulton Medical Center	Yes
North Fulton Medical Center	Yes
Spalding Regional Medical Center	Yes
Tanner Medical Center Carrollton	Yes
Tanner Medical Center – Villa Rica	No
Piedmont Fayette Hospital	No
Piedmont Newnan Hospital	No
Piedmont Mountainside Hospital	No
Piedmont Hospital	No
Northside Hospital - Cherokee	No
Northside Hospital - Forsyth	No



Northside Hospital	Yes
DeKalb Medical Center	No
DeKalb Medical Center at Hillandale	No
Gwinnett Medical Center	No
Gwinnett Medical Center –Duluth	No
Emory-Adventist Hospital	Yes
Emory University Hospital Midtown	Yes
Emory Eastside Hospital	No
Emory University Hospital	Yes
Emory Johns Creek Hospital	No
WellStar Cobb Hospital	Yes
WellStar Kennestone Hospital	Yes
WellStar Paulding Hospital	Yes
WellStar Douglas Hospital	Yes
Barrow Regional Medical Center	No
Cartersville Medical Center	Yes
Grady Memorial Hospital	Yes
Henry Medical Center	No
Newton Medical Center	No
Rockdale Medical Center	No
Saint Joseph’s Hospital of Atlanta	Yes
Southern Regional Medical Center	No
Walton Regional Medical Center	Yes

## APPENDIX C: CON requirements for uncompensated care

This chart shows the amount of uncompensated care a hospital was required to render in 2008, the amount the hospital actually rendered, and the percentage of their annual adjusted gross revenue that the amount actually rendered exceeded the amount required.<sup>lxiii</sup> In the column marked “Amount of uncompensated care required by CON law,” hospitals with a \$0 held no obligation to provide uncompensated indigent and charity care, but all still provided a level of uncompensated care. These hospitals are Emory-Adventist Hospital, Grady Memorial Hospital, WellStar Paulding Hospital, Cartersville Medical Center, Barrow Regional Medical Center, Emory University Hospital and Emory University Hospital Midtown.

Hospital	Amount of uncompensated care required by CON law	Amount actually rendered	Percentage of AGR as uncompensated care that went above what was required
Atlanta Medical Center	\$17,731,325	\$33,269,792	2.63 percent
South Fulton Medical Center	\$9,869,536	\$10,204,035	0.1 percent
North Fulton Regional	\$13,316,134	\$9,617,269	- 0.83 percent
Spalding Regional Medical Center	\$9,488,125	\$39,458,207	9.48 percent
Tanner Medical Center – Carrollton	\$6,109,804	\$11,693,651	3.03 percent
Tanner Medical Center – Villa Rica	\$1,771,213	\$4,709,227	4.98 percent
Piedmont Fayette Hospital	\$10,363,501	\$16,971,709	1.91 percent
Piedmont Newnan Hospital	\$4,791,082	\$7,748,294	1.85 percent
Piedmont Mountainside Hospital	\$2,202,268	\$7,920,013	7.79 percent
Piedmont Hospital	\$35,967,301	\$36,559,111	0.05 percent
Northside Hospital - Cherokee	\$4,666,751	\$14,639,658	6.41 percent
Northside Hospital - Forsyth	\$7,954,688	\$16,778,052	3.33 percent
Northside Hospital	\$41,102,172	\$50,501,881	0.69 percent
DeKalb Medical Center	\$13,422,690	\$16,206,448	0.62 percent

DeKalb Medical Center at Hillandale	\$2,896,533	\$4,701,159	1.87 percent
Gwinnett Medical Center	\$18,645,131	\$55,787,564	5.98 percent
Gwinnett Medical Center - Duluth	\$6,145,567	\$10,584,296	2.17 percent
Emory-Adventist Hospital	\$0	\$11,882,625	12.09 percent
Emory University Hospital Midtown	\$0	Not immediately available, though I/C care was rendered	Not available
Emory Eastside Hospital	\$11,915,050	Not immediately available, though I/C care was rendered	Not available
Emory University Hospital	\$0	Not immediately available, though I/C care was rendered	Not available
Emory Johns Creek Hospital	\$3,070,320	\$3,162,117	0.09 percent
WellStar Cobb Hospital	\$13,357,529	\$30,105,299	3.76 percent
WellStar Kennestone Hospital	\$29,117,753	\$55,912,254	2.76 percent
WellStar Paulding Hospital	\$0	\$2,971,584	5.65 percent
WellStar Douglas Hospital	\$4,464,448	\$9,385,058	3.31 percent
Barrow Regional Medical Center	\$0	\$9,217,862	15.5 percent
Cartersville Medical Center	\$0	\$16,862,489	6.18 percent
Grady Memorial Hospital	\$0	\$293,547,705	32.32 percent
Henry Medical Center	\$8,373,749	\$8,742,480	0.13 percent
Newton Medical Center	\$4,271,280	\$9,410,055	3.61 percent
Rockdale Medical Center	\$5,579,522	\$5,651,009	0.04 percent
Saint Joseph's Hospital of Atlanta	\$17,073,719	\$20,360,297	0.58 percent

Southern Regional Medical Center	\$11,667,824	\$40,573,333	7.43 percent
Walton Regional Medical Center	\$2,225,904	\$7,198,648	6.7 percent

## APPENDIX D: Federal poverty guidelines

Persons in family	Poverty guideline – 100 percent	130 percent	200 percent
1	\$10,830	\$14,079	\$21,660
2	14,570	18,941	29,140
3	18,310	23,803	36,620
4	22,050	28,665	44,100
5	25,790	33,527	51,580
6	29,530	38,389	59,060
7	33,270	43,251	66,540
8	37,010	48,113	74,020

For families with more than 8 persons, add \$3,740 for each additional person.

## APPENDIX E: The Indigent Care Trust Fund

Hospitals participating in the ICTF must:

- Treat low-income patient for free or on a sliding scale;
- Notify patients being admitted to the hospital as well as the public that it receives ICTF funds;
- Let patients know how to apply for help from the ICTF;
- Not require eligible patients to pay a deposit upon admittance to the hospital;
- Help patients apply for ICTF funds before or after treatment; and,
- Help patients from any county in Georgia, regardless of whether that is the county where they live.

For most hospitals, the ICTF does not cover doctor bills or Medicare deductibles.

To apply, patients must either fill out an application at the hospital upon discharge or call the hospital's business office and ask for the person who handles patient accounts or billings, or the hospital's social worker, if they have one. Once the patient has contacted the hospital and completed an application, the hospital has five business days to make a decision as to whether the patient is eligible for free or sliding scale care.

If a hospital rejects an application, the patient has the right to ask the hospital to reconsider his or her application. If a denial is issued again, the patient has the right to appeal to the state for eligibility. Patients must send a written complaint to the Department of Community Health (DCH) explaining why he or she feels the hospital was wrong in denying his or her application, and request that DCH asks the hospital to change its decision. A copy of that complaint should also be sent to the hospital. Appeal requests should be sent to:

Indigent Care Trust Fund, Hospital Reimbursement Services  
Department of Community Health  
PO Box 38490  
Two Peachtree Street, NW  
Atlanta, GA 30303-3159

## **APPENDIX F: Sample notification and application**

The below samples of notice of financial availability and sample financial policy information are pulled directly from the Department of Community Health's Policies and Procedures for Hospitals, Appendix Q.

[Sample sign to be posted in facility. The signs should be printed in large format (at least 14" by 17"). Signs should be placed as specified in the required areas in a prominent spot so that patients can easily read it.]

### **Help Getting Health Care Services & Help with Your Hospital Bills**

This hospital participates in the Georgia Indigent Care Trust Fund. As our patient, you receive certain benefits under the Trust Fund.

You have a right to:

- The availability of free and reduced-charge services
- The ability to gain admittance without pre-admission deposits
- Not be transferred solely or insignificant part for economic reasons
- The availability of services provided
- The terms of eligibility for free and reduced services
- The application process for free and reduced-charges
- The person or office to which complaints or questions about the hospital's participation in or operation of the program may be directed

Help with your hospital bills:

You may be eligible for financial help with your bills for inpatient and outpatient services at this hospital. Under the Trust Fund, we offer a certain amount of free and reduced-charge care each year. Apply at \_\_\_\_\_.

If you have any concerns about how we operate programs under the Trust Fund rules, please let us try to work with you to resolve them. However, if you are not satisfied with our handling of your situation, you may call the Department of Community Health toll-free at (877) 261-3117.

**SAMPLE**

[Sample Individual Notice of Availability for Free or Reduced-Charge Services]

**Do you need help with your hospital bill?**

If you do not have insurance to cover your hospital bill, and you have low income, you may qualify for help under Georgia’s Indigent Care Trust Fund.

This hospital participates in the Georgia Indigent Care Trust Fund. We receive special funding to assist qualified patients with their medical bills. This year we will provide a certain amount of services to patients free or at a reduced charge.

Apply at \_\_\_\_\_ (office and telephone number). We will make a decision on whether you are eligible within 5 working days. We will give you a written notice of our decision.

**The income guidelines are as follows:**

**Free Services:**

Family size	Income/Mo.
1	
2	
3	
4	
Each additional	

**Reduced-Charge Services:**

Family size	Income/Mo.	20%	Income/Mos.	40%	Income/Mos.	60%
1						
2						
3						
4						
Each additional						

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## Citations and endnotes

- <sup>i</sup> Georgia Department of Community Health Annual Hospital Financial Survey, which includes information on their uncompensated care, their cost to charge ratio, their annual adjusted gross revenue, and other such information.
- <sup>ii</sup> Census.gov
- <sup>iii</sup> Percentages of the poverty level are calculated through simple math. For example, in 2010, the federal poverty level for a family of one was \$10,830. To calculate a percentage, you simply multiply the number by the percentage amount. For example, to calculate 301 percent of the poverty level for a single person, multiply \$10,830 by 3.01.
- <sup>iv</sup> Andrews, Michelle. "Deaths Rising for Lack of Insurance, Study Finds," *New York Times*, Feb. 26, 2010.
- <sup>v</sup> *Ibid.*
- <sup>vi</sup> "Alternatives for funding indigent care beyond the public hospital," Fulton County, Ga. November 2007.
- <sup>vii</sup> *Ibid.*
- <sup>viii</sup> "Southern Regional CEO leaving," *Atlanta Business Chronicle*, December 19, 2008.
- <sup>ix</sup> *Ibid.*
- <sup>x</sup> *When Coverage Fails: Causes and Remedies for Inadequate Health Insurance, Community Catalyst, April 2009.*
- <sup>xi</sup> Top nine health industry issues in 2009, PriceWaterhouseCooper, December 2008.
- <sup>xii</sup> Mullahy, James and Wolfe, Barbara L. "The Poor often Lack Access to Health Care." In *Is Poverty a Serious Threat? Issue* Detroit: Greenhaven Press, 2006.
- <sup>xiii</sup> Mullahy and Wolfe.
- <sup>xiv</sup> "Expiration of COBRA subsidy: Millions of Unemployed Workers and Their Dependents Are at Risk; Many Will Lose Their Subsidy as of December 1, 2009." *Families USA*, December 2009.
- <sup>xv</sup> *Ibid.*
- <sup>xvi</sup> For family health coverage in the state, the employer's portion of annual premiums rose from \$4,964 to \$8,360 (a difference of \$3,395), while the worker's portion rose from \$1,673 to \$3,092 (a difference of 1,419).<sup>xvii</sup>
- <sup>xvii</sup> [http://www.epi.org/publications/entry/webfeatures\\_econindicators\\_income\\_20080826](http://www.epi.org/publications/entry/webfeatures_econindicators_income_20080826)
- <sup>xviii</sup> Zeldin, Cindy and Rukavina, Mark. *Borrowing to Stay Healthy: How Credit Card Debt Is Related to Medical Expenses* (New York: Demos and The Access Project, 2007).
- <sup>xix</sup> Tamkins, Theresa. "Medical bills prompt more than 60 percent of bankruptcies." *CNN.com*, June 05, 2009.
- <sup>xx</sup> Gordon, Alice. "Fulton County closing mental health clinics for the poor." *Atlanta Progressive News*, May 25, 2010.
- <sup>xxi</sup> Gardner, Amanda. "One-third of Uninsured are chronically ill." *US News and World Report*. August 04, 2008.
- <sup>xxii</sup> The Joint Commission. Root causes of sentinel events.
- <sup>xxiii</sup> University of California, Irvine in 2007
- <sup>xxiv</sup> *Ibid.*
- <sup>xxv</sup> "Breaking the Language Barrier: Health Care Quality, Efficiency and Savings through Professional Medical Interpretation" Louis F. Provenzano, Jr., President and Chief Operating Officer, Language Line Services, June 2009
- <sup>xxvi</sup> *Ibid.*
- <sup>xxvii</sup> *Ibid.*
- <sup>xxviii</sup> National Networks of Libraries of Medicine, <http://nmlm.gov/outreach/consumer/hlthlit.html>
- <sup>xxix</sup> There is one rail stop in Clayton County at Hartsfield International Airport.
- <sup>xxx</sup> [www.itsmarta.com](http://www.itsmarta.com)
- <sup>xxxi</sup> <http://www.bartowga.org/transit/index.html>
- <sup>xxxii</sup> <http://cats.cherokeega.com/fixedroutess.pdf>
- <sup>xxxiii</sup> Katz, Mitchell H., MD. "Decreasing Hospital Costs While Maintaining Quality." *Archives of Internal Medicine*, February 22, 2010.
- <sup>xxxiv</sup> Emory Healthcare is a partial owner of Emory Eastside and Emory Johns Creek.
- <sup>xxxv</sup> Karkaria, Urvaksh. "LifePoint buys Rockdale Hospital for \$80M+" *Atlanta Business Chronicle*, February 06, 2009.
- <sup>xxxvi</sup> As explained later in the report, DSH funds are meant offset financial losses on uninsured, underinsured and low-income individuals, as defined by the state plan in accordance with federal regulations
- <sup>xxxvii</sup> Many hospitals are, though, owned by a system that does have some tax obligations.
- <sup>xxxviii</sup> Congressional Budget Office (CBO), "Not-for-profit Hospitals and the Provision of Community Benefits," December 2006.
- <sup>xxxix</sup> Salinsky, Eileen. "What Have You Done For Me Lately? Assessing Hospital Community Benefit," *National Health Policy Forum*, April 19, 2007.
- <sup>xl</sup> A bond, issued by a municipal, county or state government, whose interest payments are not subject to federal income tax, and sometimes also state or local income tax. Of the \$50 billion in tax-exempt private-activity bonds issued by state and local governments in 2002, about \$10 billion went to not-for-profit hospitals. Access to tax-exempt financing lowers the cost of capital for not-for-profit hospitals. The Congressional Budget Office (CBO) estimates that, in 2006, the cost of capital for not-for-profit hospitals was 10.8 cents per dollar of investment, compared with 12.9 cents per dollar for for-profit hospitals.
- <sup>xli</sup> Karkaria, Urvaksh. "Rival hospital deal could spell new owner for Saint Joseph's." *Atlanta Business Chronicle*, April 09 -15, 2010
- <sup>xlii</sup> Karkaria, Urvaksh. "Piedmont, Henry Medical in partnership talks." *Atlanta Business Chronicle*, April 02-08, 2010.
- <sup>xliiii</sup> Learn more about FQHC's at <http://www.cms.hhs.gov/center/fqhc.asp>
- <sup>xliv</sup> Bartow, Fayette, Henry, Newton, Paulding, Pickens, Rockdale, Spalding and Walton counties.
- <sup>xlv</sup> Georgia Free Clinic Network, [gfcn.org](http://gfcn.org)
- <sup>xlvi</sup> Sack, Kevin. "The Breaking Point," a series of articles dedicated to the topic of Grady Memorial Hospital and its dialysis situation published in the *New York Times* between Nov. 21, 2009, and Jan. 6, 2010.
- <sup>xlvii</sup> <http://oasis.state.ga.us/>
- <sup>xlviii</sup> <http://www.gha.org/pha/Provider/publications/StateOfTheHealth/2008/SOTHConditions2008.pdf>
- <sup>xlix</sup> <http://cdc.gov/nchs/data/nhsr/nhsr007.pdf>

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<sup>i</sup> Katz, Mitchell H., MD. “Decreasing Hospital Costs While Maintaining Quality.” *Archives of Internal Medicine*, February 22, 2010.

<sup>ii</sup> Georgia Department of Community Health Annual Hospital Financial Survey, 2007.

<sup>iii</sup> Katz.

<sup>iiii</sup> Ibid.

<sup>iv</sup> Ibid.

<sup>lv</sup> Georgia’s Certificate of Need (CON) program is a permit hospitals must receive from the state of Georgia before they are allowed to offer new services to patients, renovate existing facilities or buy new equipment.

<sup>lvi</sup> Designated trauma centers will only pay 1.4 percent

<sup>lvii</sup> Net patient revenue reflects revenue for patient care only and does not include revenue from other operations such as the cafeteria, parking.

<sup>lviii</sup> Miller, Andy. “Hospitals mine data to identify those likely to pay,” *Atlanta Journal-Constitution*, April 19, 2009.

<sup>lix</sup> Adjusted gross revenue is gross revenue minus adjustments to that revenue amount.

<sup>lx</sup> Grady Memorial is largely staffed by residents from Emory University School of Medicine and Morehouse School of Medicine, both of which first pay their doctors, and are then later reimbursed by Grady Memorial. At the height of its crisis in 2007, Grady Memorial owed \$67 million to the Emory, which forgave \$20 million of that debt in 2009.

<sup>lxi</sup> <http://www.marketingcharts.com/interactive/home-internet-access-in-us-still-room-for-growth-8280/nielsen-internet-access-household-income-february-2009jpg/>

<sup>lxii</sup> Department of Community Health, Annual Hospital Financial Survey