NYC HEALTH + HOSPITALS

New York City Council

Oversight Hearing – Charity Care Funding

in New York City Hospitals

Committee on Hospitals

Mitchell Katz, M.D.

NYC Health + Hospitals

President and Chief Executive Officer

January 16, 2019

Good afternoon Chairwoman Rivera, and members of the Hospitals Committee. I am Mitchell Katz, M.D., President and Chief Executive Officer of the NYC Health + Hospitals ("Health + Hospitals"). Thank you for the opportunity to appear before you today to share the key elements of Health + Hospitals wide-ranging proposal to rebalance the distribution of New York State hospital indigent [or charity] care funding, while remaining fiscally prudent and staying within the constraints of the New York State Medicaid Global Cap. The proposal was submitted to the temporary *New York State Indigent Care Workgroup*[1], of which I was a member, in November. The workgroup was charged with preparing a report on its findings and recommendations, which has not been released yet.

As you know, Health + Hospitals is New York City's single largest provider of care to Medicaid patients, those with behavioral health needs, and the uninsured. Our core mission is providing universal access to high quality health care services to 1.1 million New Yorkers, regardless of their ability to pay, or their immigration status. Nearly 70% of Health + Hospitals inpatient care is provided to low-income Medicaid and uninsured patients, compared to less than 40% of stays for other New York City

[1] The indigent care workgroup was a requirement of an agreement between the Governor and the NYS Assembly for the enactment of the SFY 2018-19 budget. The agreement stated "The Department [of Health] will establish a temporary workgroup on hospital indigent care methodology which will make recommendations regarding Disproportionate Share Hospital (DSH) and Indigent Care Pool (ICP) funding. The workgroup shall convene no later than June 1, 2018 and create a report on its findings no later than December 1, 2018."

Hospitals,[2] and half of all uninsured hospital stays and uninsured emergency department visits in New York City occur at Health + Hospitals facilities – a disproportionate share compared to every other health system in the City.[3]

While New York State's Medicaid program provides robust health coverage for millions of low-income individuals, Medicaid reimbursement rates have not adequately covered hospitals' costs for providing care to the most vulnerable among us. As such, the federal Medicaid disproportionate share hospital (DSH) program payments to all hospitals – public and voluntary/not-for-profit – to offset their uncompensated costs is a critical funding source for our financial stability.

Disproportionate Share Hospital Program

Each year, New York State distributes approximately $3.5 billion[4] gross in DSH funding to both public and voluntary hospitals. As the largest provider of Medicaid/uninsured care in New York State – treating over 380,000 uninsured patients, and approximately 600,000 Medicaid beneficiaries – Health + Hospitals is the largest recipient of the State's DSH funds, and has on average received about $1.4 billion in funding.

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[2] Analysis of 2012-2014 Statewide Planning and Research Cooperative System (SPARCS)
[3] Ibid.
[4] NYS receives 14.7% of nationwide federal DSH funding, resulting in approximately $3.5 billion of gross DSH to distribute to NY hospitals.

Under the Affordable Care Act (ACA) DSH funding was reduced with the assumption that most uninsured will be eligible for health insurance, which would mean less hospital uncompensated care, and therefore less DSH funding. However, that has not borne true. From 2013-2014, New York hospitals' total uncompensated care losses increased by $645 million, which reflects an $835 million increase in Medicaid losses offset by a reduction in their losses from treating uninsured patients of $190 million.[5] Under the current federal law, and draft federal rules, New York State's gross DSH cut could be $1.3 billion[6] in FFY 2020, and $2.6 billion FFY 2021-25. Without a change to current State law, Health + Hospitals would be first in line for federal DSH cuts, as it is last in line for funding. This would result in Health + Hospitals receiving the first $700 million in cuts in FFY 2020, before any other hospitals DSH funding is reduced.

The Council has been instrumental in previous advocacy efforts to delay DSH cuts, especially you Chairwoman Rivera. We look forward to continue working with you to fight back these damaging cuts.

New York State is charged with distributing federal DSH payments to hospitals pursuant to a formula in State law, which requires funding to **first** be distributed to state hospitals (including mental hospitals), **second** to voluntary and public

[5] GNYHA analysis of CMS Medicaid DSH cap audit data, 2013 and 2014.
[6] NYS could receive 16% or more of the national cut ($4 billion) in FFY 2020; ($8 billion) each year from FFY 2021 – 2025.

hospitals[7] through the indigent care pool (ICP) and other allocations, and **third** to Health + Hospitals, which receives the remaining funds after DSH payments are made to all other hospitals throughout the State.

With such large reimbursement cuts looming on the horizon, New York State should move towards driving more DSH funding to hospitals that provide the most care to low-income and uninsured patients. As was previously stated, Health + Hospitals is the safety-net for New Yorkers, and is the largest provider of Medicaid/uninsured care in New York State. The money should follow the patient.

Indigent Care Workgroup/Health + Hospitals Proposal

As I mentioned earlier, I was a member of the *Indigent Care Workgroup*, which was charged with making recommendations on reforming DSH and ICP funding. Members of the workgroup were from the hospital/health plan and consumer/labor sectors, and met four times from July through November. Several proposals were advanced for consideration, including ones from the Healthcare Association of New York State; the New York State Department of Health; the New York State Nurses Association; and Health + Hospitals/Community Coalition – a coalition of community advocates and labor representatives.

[7] For non-Health + Hospitals public hospitals, the non-federal share of DSH funds comes from their respective local governments via intergovernmental transfers (IGT).

The Health + Hospitals/Community Coalition proposal was predicated on a set of principles based on a fair and equitable approach to allocate a greater proportion of ICP funds to those hospitals that provide services to uninsured and Medicaid populations – the enhanced safety net hospitals and at-risk/needy hospitals. Our proposal would 1) eliminate the ICP "transition collar," 2) increase Medicaid rates, and 3) optimize federal funding. This proposal is distinct from our advocacy to ensure federal DSH cuts do not happen.

Below I provide background and more specifics on three proposals advanced to the indigent care workgroup.

1. **Elimination of the Indigent Care Pool (ICP) "Transition Collar**:" In 2012, the State sought to better align ICP funding with provision of indigent care, and developed a methodology to distribute the funds based largely on the number or "units of service" a hospital provides to the uninsured. In order to protect hospitals from large fluctuations in revenues under the new methodology, a 3-year "transition collar" was put in place. This meant that in the first year, no hospital could lose more than 2.5% of its previous 3-year average in ICP funding. By the end of the third year, no hospital could lose more than 7.5% of its previous three-year average. In 2015, the NYS Legislature authorized another three years of transition payments, and by

2018, no hospital could lose more than 15% of its previous three-year average in ICP payments.[8]

The unintended consequence of extending the "transition collar" is some hospitals who serve the fewest uninsured continue to benefit from the pre-2012 ICP allocations, while some safety-net institutions, such as Health + Hospitals that provide care to large numbers of uninsured and Medicaid patients, are underfunded.

Proposal: Remove the "transition collar" and reduce ICP funding for all hospitals in order to reinvest the funding in Medicaid rate increases for Safety Net and At-Risk/Other Needy hospitals.

2. **Enhancement of Medicaid rates for Safety Net and At Risk/Other Needy Hospitals:** Since passage of the ACA, Medicaid rates have stagnated, and have created ever increasing financial jeopardy and instability for hospitals that disproportionately provide essential safety net services to low income and at-risk communities. On average, two-thirds of New York State hospital DSH caps are now generated by losses on Medicaid services, rather than the uninsured. This has contributed to a growing disparity between hospitals that

[8] "Unintended Consequences – New York State Patients and Safety-Net Hospitals Are Shortchanges." Community Service Society of New York. January 2018.

have greater access to commercial payers and those that are dependent on public insurance programs.

Proposal: Invest funds reduced from the ICP into across the board rate increases, or increases weighted to prioritize ambulatory and primary care. The funding split between publics and voluntary enhanced safety net and at risk/other needy providers would remain proportional to the public/voluntary shares of ICP funding. There would also be dedicated funding for Critical Access Hospitals.

3. **Optimization of available federal funding to support these essential services:** The reduction in ICP funds reduces the State's DSH spending, leaving that portion of the state-wide federal DSH allotment still available to be drawn down. Public hospitals can use Intergovernmental Transfers (IGTs) from their sponsoring entities to retain these federal funds. We assume that Health + Hospitals would access two-thirds of this federal funding, with the remaining third going to other public hospitals across the State.

Protect Safety-net and At-Risk/Needy Hospitals:

Our proposal as outlined ensures that the bulk of hospitals identified as Safety Net and At Risk/Other Needy providers gain needed resources to support their care of uninsured and Medicaid patients. To ensure that all Safety Net and At Risk/Other Needy hospitals receive the maximum possible funding, we propose that the State

expand existing programs for financially distressed hospitals. These expansions would be modest and can be achieved within existing funds at no additional cost to the State.

By taking a broad view of the needs of Safety Net and At Risk/Other Needy hospitals, this proposal is able to implement elimination of the ICP "transition collar," without jeopardizing essential hospitals providing services to needy communities. Moreover, it increases Medicaid reimbursement for those hospitals in recognition of the connection between unsustainably low Medicaid rates and the vulnerable financial position of these providers. The proposal also leverages new federal Medicaid funds, while retaining all existing federal DSH funds, allowing increased DSH funding for public hospitals.

Thank you for the opportunity to testify before you today on an important issue to Health + Hospitals and safety net providers across the State and the City. I look forward to answering any questions you may have.

Testimony of Judy Wessler
Retired Director
Commission on the Public's Health System
January 16, 2019
New York City Council Hospitals Committee

Thank you for the opportunity to testify today about my 35 year-long experience advocating for changes in the Indigent Care/Charity Care pool program in New York State. This is not a technical paper, which I could also write, but rather a sad history of efforts that i was involved in to attempt to make the history of this program a bit less sordid and redirect funding where it could be most useful in providing care for people.

When a funding program was once announced I was working at Community Action for Legal Services, now named Legal Services of New York, as the Health Advocacy Coordinator. In that role, I was responsible for working with community based organizations and acting as a liaison between those organizations and the lawyers and paralegals. We were aware of, and helped individuals and families that had access to health care services. It was thus surprising and encouraging to see an announcement that funding for hospitals to pay for the care of the uninsured was coming available. With several of the lawyers, we drafted a memorandum to the State Health Department recommending the use of the procedure and form in use for patients to apply for free or below cost care under the Hill-Burton program. Under this federal program, hospital receiving capital funding were required to set up a program in which patients could apply for free care. In addition, when a 20-year requirement was fulfilled, hospitals had an obligation to continue providing care to all patients but no longer had to provide the care for free. Working with a lawyer at MFY Legal Services, we sued Beth Israel Medical Center on behalf of two Lower East Side resident (Corum v. Beth Israel) on the basis that the hospital did not have a sliding fee scale in its clinics so care was not available there for the uninsured.

So this long history of working to ensure that the uninsured had some access to care began way back then. Unfortunately, the State Health Department chose to ignore our very practical recommendation and instead developed complicated method of reimbursing hospitals. Their methodology most often had very little to do with access to care for the uninsured. Much of the funding appeared to pay for bad debt, where full payment is not available even from insurance companies, instead of targeting payment for care of people who could not pay. Now 35 years later, even with federal legislation backing the need to use the federal portion of the dollars to pay for care of the uninsured, we are still struggling to get the state to do the right thing. Some questionable politics keep happening so we are still fighting this one out.

As first Policy Coordinator and then Director of the Commission on the Public's Health System (CPHS) for 18 years, the issue of fair funding and providing care for the uninsured continued to be a major

issue of concern. Work continued on efforts to appropriately redirect the charity care funding to those hospitals that actually provided the care. This also led to a focus on supporting the public health and hospital system, (HHC/H and H), because of the system's legal commitment to providing care for people regardless of their ability to pay. CPHS worked hard with some of the really good people that worked at HHC to develop the HHC Options program and to ensure a sliding fee scale for access to medications.

There was an effort in 2008 by the State Health Department to develop a new way of distributing money. A proposal developed by a Task Force was not endorsed by the state legislature after fierce lobbying by the private hospitals and Local 1199.

Another effort was tried in 2011-2012 when new Governor Andrew Cuomo was elected. He set up the Medicaid Redesign Team (MRT) make recommendations on ways to reduce the state's Medicaid budget by over $2 billion. Some of the work done by CPHS during this period can be found at (http://www.cphsnyc.org/cphs/What_We_Do/charitycare/). CPHS had a foundation grant to hire a professor to develop a new proposal to present to committees of the MRT. (http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/). This report was developed with a committee of labor representatives and community groups. Presentations were made to two committees of the MRT: the Disparities Committee and the Payment Reform Committee.

The governor and the Health Department chose to accept the recommendation of the provider-dominated payment reform committee. A smaller committee of this group met in secret and also punted on needed changes in the distribution methodology. The result was a transition for three years (called the Collar), which protected hospitals from losing much money -- thus again not directing the funding toward paying for the care of the uninsured and targeting high Medicaid-serving hospitals. This is actually language that can be found in the federal Affordable Care Act.

Work was performed in-between then and now, including reports providing documentation that the money was not going where it should be going, but little changed.

In the 2018 legislative session, the Assembly stimulated by Health Committee Chair Dick Gottfried convinced the state to include a side letter in the budget for a commitment that a Work Group would be set up to make recommendations for changes in the Charity Care distribution methodology. The group was set up and met four times. Two excellent proposals were submitted by the NYCH+H/community coalition and another by the New York State Nurses Association. These two proposals would finally right the long wrongs and would ensure that more dollars would flow to the state-defined Enhanced Safety Net Hospitals and other community hospitals in need. I am sure that you will hear presentations about these proposals, so I won't spend the time here giving the details.

What is important to know is that we need your help of the committee and the New York City Council to take this issue on and ensure that Indigent Care Pool funding is distributed to hospitals that are providing the care and are not rich with surpluses largely being used to buy up other hospitals. It is well beyond time to address these inequities.

Health Policy Webinar: Making Indigent Care Pool Funding Fair

Friday, January 11, 2019

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Audio PIN: Shown after joining the webinar

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Webinar Objectives

- Provide information and background on Disproportionate Share Hospital and Indigent Care Pool funding
- Provide information about the 2018 NYS DOH ICP Workgroup
- Introduce the H+H Community ICP proposal
- Present community and labor advocates advocacy agenda
- Urge action!

Hospital Uncompensated Care Funding

- Federal: Disproportionate Share Hospital ("DSH") Funds
  - Federal financing mechanism to provide funding to hospitals that provide large volumes of care to Medicaid beneficiaries and uninsured patients
  - NYS is biggest recipient out of all the states (16% of all DSH funds)

- State: Indigent Care Pool (ICP) Funds
  - For decades, NYS has run the ICP to provide support to hospitals for offset their losses providing care to financially needy patients.
  - Was called the "Bad Debt and Charity Care Pool", now called the "Indigent Care Pool"
  - It is partially funded by DSH
  - Since 2000, the pool has been criticized by patient advocates for:
    - Not being transparent, unclear how funds were spent and why certain hospitals received funds when it appeared they provided little care to financially needy patients
    - Not tying the funds directly to patients who received free/discounted care
    - Funding hospitals that didn't have financial assistance policies.

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NYS' DSH Funding Distribution

- NYS receives approximately $3.6 billion in DSH funding.
- NYS distributes $1.134B through the ICP composed of $139M in **Public Hospital Indigent Care funds** and $995M in **Voluntary and Non-Major Public Indigent Care funds**

General Framework for Distribution of NYS DSH Allotment ($millions)				
(Amounts based on FFY17 $3.5B Statewide Allotment, Preliminary FFY 18 Allotment is $3.6B)	**Voluntary**	**H+H**	**Other Publics**	**Total**
Indigent Care Pool (State/Federal Funds)	$656	$95	$44	$795
• Separate fixed pools for publics and voluntaries. • 2012 ICP Reform Workgroup Methodology: Around 85% of funds distributed based on Medicaid and uninsured units of service. • $339 is comprised of voluntary UPL for DSH Swap $656 + $339 = $995				
Indigent Care Adjustment Pool (Local/Federal Funds)	$0	$256	$156	$412
• Fixed pool for publics. • Distributed based on Medicaid and uninsured losses (DSH Caps).				
Public Hospital IGTs (Local/Federal Funds)	$0	$1,045	$668	$1,713
• Other Publics: guaranteed hospital cap payment, reconciled on a lag. • H+H: $330M plus any remaining federal funds in the Statewide Allotment after all other payments. *(total H+H based on 3-Year avg. share)*				
NYS OMH Psych Hospitals (State/Federal Funds)	$0	$0	$605	$605
• Fixed allocation for mental health institutions.				
Total DSH	**$995**	**$1,396**	**$1,473**	**$3,525**

Indigent Care Pool	
Voluntary DSH (including $25m transition funds)	**$656**
Voluntary UPL	**$339**
Public DSH	**$139**
TOTAL	**$1,134**

Background on Proposed DSH Cuts

- The Affordable Care Act (ACA) reduced DSH payments nationally because uninsured would be eligible for ACA insurance
  - But States like NY, have large number of ACA-ineligible individuals (i.e. immigrants and people who cannot afford coverage). Hospitals also continue to need DSH because of low Medicaid reimbursement rates.
- NYS receives 16% of nationwide federal DSH funding, resulting in approximately $3.6 billion of DSH to distribute to NY hospitals.
  - NYS' gross DSH cut could be $1.3 billion in FFY 2020 and $2.6 billion in FFY 2021.
- H+H is the largest recipient of NYS DSH funds and has on average received about $1.4 billion in DSH funding.
  - NYC Health + Hospitals (H+H) still serves ~382,000 uninsured individuals annually
  - Without a change to the current state law, H+H will bear the initial brunt of any federal cuts – at least the first $700 million and up to $870 million in the first year.

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Background on ICP Funding

- The $1.1 billion ICP is designed to compensate hospitals for uncompensated care
- 2012 Reforms
  - Change payment method to compensate hospitals for actual services provided to uninsured and Medicaid enrollees consistent with anticipated federal guidance (85% of funds)
  - Created a 3 year transition "collar", to limit a hospital's exposure (around 15% of the funds):
    - Formula limited losses to 2.5% first year, growing by 2.5% each year
    - Hospital gains also limited, creating "collar"
- 2015: State extended 3-year transition period by additional 3 years (2018 – 15% = maximum loss)
- 2018: Enacted budget extends transition period by one year
- Future – if extensions continued, the collar will not close until the year 2050…

Indigent Care Pool	
Voluntary DSH (including $25m transition funds)	**$656M**
Voluntary UPL	**$339M**
Public DSH	**$139M**
TOTAL	**$1,134M**

What are the issues?

1) Allocation of DSH Funding
   - The sequencing of NYS DSH funds allocations means the hospitals which provide the most care to Medicaid and uninsured people get paid last, not first.
   - **Solution: Adopt new formula to allocate DSH funds in NYS that benefits true safety hospitals and patients**

2) ICP Transition Collar
   - The roughly $140 million transition collar uses the old formula, based on bad debt, and rewards some hospitals that fail to serve the uninsured
     - Charity Care – cost of care for patients given discounts based on income
     - Bad debt – cost of care to patients NOT given discounts, including patients sent to collections, as well as unpaid cost-sharing for insured patients (i.e. deductibles, co-pays)
   - DSH dollars more critical than ever, NY should spend them wisely
   - States that do not use DSH funds for hospitals disproportionately serving Medicaid and uninsured patients will be penalized in the distribution of federal DSH cuts
   - **Solution: End transition collar and tie ICP payments to true safety hospitals and patients**

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In 2018 an ICP Workgroup was formed to address these issues

- The Governor and Legislature agreed in a side letter out of the State 2019 budget to form a NYS Indigent Care Workgroup:

  "The Department will establish a temporary workgroup on hospital indigent care methodology which will make recommendations regarding Disproportionate Share Hospital (DSH) and Indigent Care Pool (ICP) funding. The workgroup shall convene no later than June 1, 2018 and create a report on its findings no later than December 1, 2018."

- The Workgroup was formed to address both problems:
  - federal DSH cuts slated to begin October 1, 2019, and
  - the ICP transition collar.

Workgroup Membership

- The Workgroup met four times but has not yet released its report.
- Co-chairs are: Bea Grause – President, HANYS; Dan Sheppard, Deputy Commissioner, NYS DOH; Elisabeth Benjamin - VP Health Initiatives, CSS

Hospitals/Health Plan	Consumers/Labor
Dr. Katz - President/CEO, NYC H+H	Lara Kassel - Medicaid Matters
Gary Fitzgerald - President, Iroquois Healthcare Alliance	Claudia Calhoon - NY Immigration Coalition
Colleen Blye - Executive VP/CFO, Montefiore	Rebecca Telzak - Make the Road NY
Phyllis Lantos - Consultant/Former CFO, NY Presbyterian	Anthony Andrews - NYC H+H/Queens CAB
Dennis Whalen – VP Government Affairs, Northwell	Sudha Acharya - South Asian Council of Social Services
Hugh Thomas - Chief Admin. Officer/General Counsel, Rochester Regional	Sharon Chesna - Mothers and Babies Perinatal Network of South Central NY
Michael Israel - President/CEO, Westchester Medical	Amanda Gallipeau - Empire Justice Center
Elisabeth Wynn - Exec. VP Health Economics & Finance, Greater NY Hospital Association	Leon Bell - NYSNA
Eric Linzer - President/CEO, Health Plan Association	Moira Dolan - DC 37
	Helen Schaub - 1199 SEIU

Workgroup Meetings

- The ICP workgroup met 4 times
- Meeting #1-#2: investigated the impact of eliminating the collar entirely
  - 99 hospitals would gain funds, but 39 would lose—including true safety net hospitals
- Meeting #3: investigated the impact of reallocating $200 million
  - Investigated 3 alternative scenarios.
  - In every scenario, a large number of safety net and "at risk" hospitals lost funds
- Meeting #4: discussion of additional ideas, including:
  - HANYS (extends the collar)
  - NYSNA
  - H+H Community Coalition – the remainder of the webinar focuses on this proposal

H+H Community Coalition

- H+H Community Coalition represents low income and at risk patients across the State and unions representing healthcare workers largely employed by safety net institutions.
- H+H Community Coalition Goals
  - Eliminate the ICP transition collar without hurting essential hospitals providing services to needy communities;
  - Enhance Medicaid rates for Safety Net and At Risk/Other Needy hospitals; and
  - Optimize new federal Medicaid funds, while retaining all existing federal DSH funds to support these essential services
- Endorsements: 9 members of the NYS Indigent Care Workgroup, 3 additional community advocates, and the One Brooklyn Health System whose three hospitals provide essential services to the Brooklyn community.

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Issues that the H+H Community Coalition seeks to address

- Eliminating the collar would hurt some hospitals that disproportionately provide essential safety net services to low income and at risk communities.
- Medicaid rates have stagnated creating and increasing financial jeopardy and instability for safety net hospitals.
- On average, two-thirds of NYS hospital DSH Caps are now generated by losses on Medicaid services, rather than the uninsured.
  - This has contributed to a growing disparity between hospitals that have greater access to profitable payers (well resourced) and those that are dependent on public insurance programs.

The H+H Community Coalition Proposal

- Eliminates the transition collar, including the associated $25 million "transition funds" investment, from the ICP distribution methodology
- Reduces the ICP by $300 million across all hospital proportionally from their allocation before the transition collar in the current methodology
- Invests $300 million ICP funds into Medicaid increases for Safety Net and At Risk/Other Needy hospitals
  - The investment is proportional to the current public and voluntary shares of the ICP
  - Assumes across the board rate increases for all services; but the state could give more weight to ambulatory and primary care services
  - Addresses the disparity between well resourced and needier hospitals, establishing a tiered Medicaid payment for safety net hospitals
- Public Hospitals have access to $150 million federal DSH formerly used for ICP

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H+H Community Proposal

Impact of redistribution of $300.0M + $12.5M to CAH's + $27.3M EP & MA VBP QIP(1)

	Gains		Reductions	
	Total Amount	# of Facilities	Total Amount	# of Facilities
Public Safety Net-HH	$ 111,476,278	12	$ -	0
Public Safety Net-Other	$ 38,523,722	8	$ -	0
Voluntary Safety Net	$ 130,279,124	53	$ -	0
At Risk (Other Needy)	$ 28,901,447	23	$ -	0
Voluntary-Other	$ 8,636,217	8	$ (152,284,839)	71
Total	**$ 317,816,788**	**104**	**$ (152,284,839)**	**71**

(1) *Includes additional $150m Federal Share to All Public Hospitals (H+H = $100m, Other Publics = $50m).*

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Benefits of the H+H-Community Coalition Proposal

- The H+H-Community Coalition Proposal achieves the following shared objectives:
  - Eliminates ICP Collar without harming safety net and other needy hospitals providing essential services to needy communities
    - Removes ICP funding linkage to historical allocations based on bad debt
    - Prioritizes ICP funds to uninsured patient care
    - Minimize allocation of federal DSH cuts to NYS
  - Increases Medicaid reimbursement for Safety Net and At Risk/Other Need hospitals.
    - Estimated 8% increase for eligible voluntary hospitals
    - Assumes across the board rate increases for all services; however, a policy approach giving more weight to ambulatory and primary care, or services concentrated at safety net providers may be appropriate
    - Establishes precedent for tiered Medicaid payments based on safety net need status
  - Leverages new federal Medicaid funds, while retaining all existing federal DSH funds, allowing increased DSH funding for public hospitals.
  - Addresses disparity between well resourced and more needy hospitals

Additional Issues of Concern for the Coalition

- H+H remains exposed to the brunt of looming federal DSH cuts. State law must be changed so H+H is not primarily reliant on a pool of leftover DSH funds, leaving it subject to fluctuating payment amounts/timing and first in line for devastating federal DSH cuts.
- The State should fully enforcing compliance with the Hospital Financial Assistance Law
  - Federal risks like the proposed Public Charge regulation which will impact access to care
  - Hospitals should be required to use 1 uniform NYS application
  - Hospitals should be rigorously monitored to ensure compliance

Call to Action - #FixHospFunding

- Fixing the inequities in hospital ICP and DSH funding requires legislative/budget action in Albany.
- The immediate priority is to ask the Governor to fix hospital funding in the Executive Budget that is to be released later in January—we still have time to influence the Executive Budget!

➢ **Call and e-mail the following message to the Governor's Office at (518) 474-8390 and at https://www.governor.ny.gov/content/governor-contact-form:**

"Governor Cuomo, fix the inequities in the distribution of state ICP and federal DSH funding in New York. These vital resources must be directed to those hospitals that provide the highest levels of health services for Medicaid and uninsured patients. Stop subsidizing profitable hospital systems that don't need the money. Adopt the H +H Community Proposal developed and supported by members of the ICP Workgroup that you convened in 2018. It would increase Medicaid reimbursement rates for safety net hospitals, leverage additional federal matching dollars for healthcare, protect the state from larger federal cuts, and provide a fairer distribution of hospital funding based on need. I strongly urge you to do the right thing and fix hospital funding in New York."

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WHAT MORE MUST BE DONE?

- Get involved and find out more: #FixHospFunding
- Sign up your organization or group as a supporter
- If we don't get the H + H/Community Proposal included in the Executive budget that is released in January, we will take this fight to the legislature to ensure that it is included in the final budget that will be finalized in late March.
- We will have further updates and information about actions after the executive budget is released.

FIX HOSPITAL FUNDING IN NEW YORK. FAIR FUNDING NOW!

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Resources

- Community Service Society of New York, "Unintended Consequences: How New York State Patients and Safety-Net Hospitals are Shortchanged," January 2018, http://lghttp.58547.nexcesscdn.net/803F44A/images/nycss/images/uploads/pubs/hospital_report_-_final_1_22_18_web.pdf
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New York City Council - Committee on Hospitals

January 16, 2019 Oversight Hearing

Re: Charity Care Funding for New York City Hospitals

Testimony of Anne Bove, RN, NYSNA Board of Directors

Chairperson Rivera and Members of the Committee on Hospitals,

I would like to thank you for giving me the opportunity to testify before you this afternoon on the issue of Charity Care Funding for New York City Hospitals.

My name is Anne Bove. I was a front line nurse employed by the New York City Health + Hospitals system. I recently retired after working for almost four decades at Bellevue Hospital Center, the oldest public hospital in the country and one of the core hospitals of the public Health + Hospitals system.

Profitable Private Hospital Networks Exploit Health + Hospitals and Safety-Net Hospitals

Health + Hospitals is not only a vital safety-net hospital that provides health care to the uninsured, underinsured and underserved communities, it is also the backbone of the entire public and private health care system in the City of New York.

Health + Hospitals provides free health care to about 400,000 uninsured New Yorkers and accounts for about 20% of inpatient hospital care and an even higher percentage of outpatient and primary care clinic services in NY City. In addition, it must be noted that Health + Hospitals provides a disproportionate share of expensive and poorly compensated Level I trauma services, in-patient and out-patient psychiatric services, and a range of other vital health care services that private sector hospitals avoid because simply because they are unprofitable and they can.

Because NYC Health + Hospitals is there to pick up the costs of caring for the uninsured and providing these poorly compensated services, the large private hospital networks are able to focus on more profitable lines of health care services that pad their bottom lines and leave the public hospitals and other safety-net providers to deal with the financial losses of providing that vital and necessary care.

The result is that NYC Health + Hospitals and other safety-net providers are set up to lose money so that the big private hospital systems can generate huge profits.

This symbiotic financial relationship between NYC Health + Hospitals and the big private hospital networks is readily apparent when we compare their financial positions. NYC Health + Hospitals loses more than $1 billion a year on patient care operations and relies on direct subsidies from the City of New York to maintain operations. The big private hospital systems, by way of contrast, earned

hundreds of millions in profits by focusing their activities on wealthier patients with good private insurance and profitable services like joint surgeries, cardiac care and cancer treatments. Thus, in 2016 NYU Langone reported net profits of $278 million, NY Presbyterian reported $324 million, Northwell reported $95 million, and Mount Sinai reported $159 million, all while NYCHH faced operating losses of about $1.1 billion. The connection between the precarious financial status of safety-net hospitals and the big private networks is pretty obvious.

Charity Care Funding In New York State Is Broken

New York hospitals are legally obligated to provide health services to patients based on their ability to pay. The Federal EMTALA regulations require hospitals to provide emergency treatment to all patients even if they cannot pay, but do not require follow-up or ongoing medical service be provided outside of the emergency room. In addition the State Hospital Financial Assistance Law (HFAL) requires hospitals to provide care in the form of zero or reduced charges based on sliding scales and the patient's ability to pay. In practice, many private hospitals shirk their obligations under these laws while NYC Health + Hospitals turns no patients away whether they can pay or not – it is no accident that the public system cares for a disproportionate share of uninsured and underinsured patients despite these laws being on the books. The dynamic at play is, again, obvious and does not require much more explaining.

The costs of caring for the uninsured and the underinsured are supposed to be at least partially compensated through the funding provided by the Federal Disproportionate Share Hospital (DSH) program. Recognizing that hospitals that *disproportionately* care for Medicaid and uninsured patients will necessarily lose money on their operations while hospitals that have higher percentages of privately insured patient and fewer uninsured will make money, the Federal DSH program distributes extra funding to the states to fix this problem.

The underlying premise of the federal DSH program is that Medicaid rates are not sufficient to cover hospital costs and provide little reimbursement to hospitals for their uninsured patients. This means that hospitals with high rates of Medicaid and uninsured patients and low rates of privately insured patients are structurally guaranteed to lose money. To keep these vital safety net hospitals from closing or slashing needed services, the federal government provides DSH funding to offset these structural losses.

New York currently receives about $1.8 billion in federal DSH funding per year. This must be matched by a corresponding $1.8 billion in state and local matching funds (the so-called FMAP or state share, which for New York is 50%). This combined pool of $3.6 billion is then distributed to hospitals to make up for their uncompensated patient care costs.

Under the DSH program each state has the authority to decide on exactly how the total pool of money is distributed to its hospitals. In New York, the $1.8 billion of the local share of the total DSH funds is mostly paid for from what is known as the "Indigent Care Pool" or ICP. The ICP is generated from state Health Care Reform Act (HCRA) taxes and fees that amount to about $1.13 billion. The remaining $700 million in local share DSH funds is paid directly through "Inter-Governmental Transfers" (IGTs) by localities, with most of that money being paid by the City of New York as the local share of the NYC Health + Hospitals DSH allocation (thus NYC H + H receives about $1.4 billion in DSH money, half of which comes from the Federal government and half from the City of New York).

Historically the NY state DSH and ICP program has been plagued by structural problems that created inequities in the way in which the federal DSH allotments and the local ICP share monies are distributed.

This results in a short changing of safety net hospitals that shoulder a disproportionate share of "charity care" and gives inordinate amounts of money to hospitals that do not need or deserve the funding they receive. In short charity care funding is not being targeted to help keep safety net hospitals operating and is enriching already well compensated private hospital networks.

Thus, we find that NYU Langone, for example, which made $278 million in profits in 2016 and continues to make huge profits, is expected to receive $50.6 million in ICP charity car funding in 2018, and NY Presbyterian, which generated $324 million in profits is expected to receive $61 million. To provide these immensely profitable hospitals with tens of millions of funding when real safety net hospitals are under laboring to provide vital services under severe financial strain is unconscionable.

This system is broken and it needs to be fixed.

Charity Care Funding Under DSH and the ICP Improperly Compensates Hospitals for "Bad Debt" Costs

The State DSH and ICP program have allowed hospitals to mix true indigent care costs (i.e., losses arising from caring for poor people who were uninsured or could not otherwise pay for the cost of their care) with bad debt losses (i.e., hospital costs that insured or well off patients refused to pay, such as co-payments or uncovered elective services).

Charity care constitutes losses by hospitals for providing free or reduced charge care to those who could not pay, and such services are a real loss. Bad debt on the other hand, reflected a failure to pay full charges, even though the hospital may have received payments that equal or exceed costs, and they are merely failing to fully collect the list-price amount that was charged. In this case, hospitals can still make a profit on providing care to the privately insured patient *and also receive ICP and DSH payments for these "losses."*

With the passage of the ACA, states were required to stop counting bad debt as charity care. New York State implemented a statutory change in 2012 to phase out the inclusion of bad debt in the distribution of DSH/ICP funds. As part of this phase out process, the state created a "transition collar" that would reduce hospitals' DSH funding by slowly phasing out bad debt from the calculation of charity care pool funding at the rate of 2.5% per year. This would allow hospitals a period of three years to "wean" themselves of improper bad debt payments. The "transition collar", however, was supposed to last only for three years, after which bad debt would no longer be used in DSH/ICP payment calculations. That timeline however keeps getting suspended, and the "transition collar" continues to allow hospitals to receive payments for their "bad debt." This not only raises questions about whether NY state is in violation of federal law and/or liable for penalties or other enforcement actions that could have serious repercussions for NY state's DSH funding and for NY hospitals, but also allows hospitals that are otherwise profitable to continue to receive DSH and ICP funding they do not deserve. This leaves less money for true safety-net hospitals.

DSH and the ICP Funding Is Not Targeted to "Disproportionate Share Hospitals"

State DSH/ICP funds are not sufficiently targeted to hospitals that provide a "disproportionate" share of Medicaid and uninsured patient care. The formulas that NY uses allocate and disperse the DSH funds in a broader manner to all hospitals instead of targeting it to those that most need it. In effect, though NY state DSH/ICP disbursement and allocation formulas do give some hospitals slightly more than others, in its essence the program as currently structured continues to provide reimbursement to all hospitals for

the losses incurred in treating Medicaid and uninsured patients, even if those hospitals generated profits from a favorable patient payer mix with high percentages of privately insured patients.

The distribution of DSH and ICP funds should be disproportionately targeted to NYC Health + Hospitals and other safety net hospitals that have the highest numbers of uninsured and Medicaid patients and the lowest numbers of wealthy and privately insured patients.

NYC Health + Hospitals Will Bear Sole Cost of DSH Cuts Scheduled to Take Effect in FY2020

The state DSH and ICP allocation formulas are set by state law and move the $3.8 billion in federal and local matching funds through a series of distribution pools. The way these pools are set up creates a final "leftover" or residual pool through which NYC Health + Hospitals receives most of its DSH funding. The NYCHH residual pool gets whatever is left after all of the earlier DSH pools are distributed and spent.

This statutory structure creates two critical problems for the NYCHH system – first it never knows with certainty how much money it will receive in any given year, and second it leaves NYCHH exposed to bearing the entire brunt of any cuts in federal DSH funding.

This second problem has become particularly in the aftermath of passage of the ACA. The ACA significantly reduced the total numbers of uninsured patients, and based on this working assumption, it called for the phasing out of DSH payments over a multi-year time frame. Though the legislated DSH cuts have been delayed several times, if there is no change in current law, significant reductions in DSH are scheduled to resume in 2019 and continue to escalate. Under the current DSH/ICP structure, *all DSH cuts will come out of the NYCHH residual pool. NYCHH will bear the full brunt of the cuts before any other hospitals are affected. It is estimated that NY State will lose up to $700 million in DSH funding in FY 2020, and all of this cut will come out of NY Health + Hospitals if there is no change in state law.*

NYSNA Fully Supports the "H + H Community Proposal" To Eliminate the Transition Collar, Target Funding to True Safety Net Hospitals, and Increase Total NY State Hospital Funding

The immediate removal of the DSH/ICP "Transition Collar" would significantly reduce funding for hospitals that do not serve a disproportionate share of Medicaid and indigent patients. It would, however, also harm some hospitals defined as "Enhanced Safety Net Hospitals" under state law and others that play vital safety net roles even though they do not meet all of the statutory criteria to qualify as ESN hospitals.

The "H+H Community Proposal" would immediately eliminate the transition collar by increasing the Medicaid reimbursement rates for Enhanced Safety Net hospitals, shifting $300 million from the DSH/ICP pools to pay the 50% local share of the increased reimbursement rates, and use various other tools to insulate ESH and near-ESN hospitals from the impact of removing the transition collar.

NYSNA particularly supports the use of tiers in the distribution of ICP/DSH monies and increased Medicaid reimbursement for ESN hospitals.

NYSNA accordingly supports the H+H Community model for the reasons that were more fully addressed by the testimony of Health + Hospitals and other supporters of the proposal.

In Addition, NYSNA Supports the Following Additional Measures to Direct Funding to Safety Net Hospitals and Reduce Funding for Profitable Hospitals That Neither Need nor Deserve DSH/ICP Funds

- Increase Medicaid reimbursement rate for all hospitals meeting the definition of Enhance Safety Net Hospitals under PHL Section 2807-c(34);
- Immediately change the priority order for distribution of DSH and ICP fund pools to remove Health + Hospitals from the "residual" or "leftover" pool that will bear the full and sole brunt of any future reductions in Federal DSH funding.
- Create Tiers of Hospitals with the ICP Voluntary Pool based on safety net status to redirect the $1.135 billion in that pool to true safety net hospitals and to eliminate funding for hospitals with low levels of Medicaid and uninsured patient or high profits.
- Change the technical formulas for distribution of ICP funds to target pool allocation to hospitals within the pool with the highest level of Medicaid and uninsured patients.
- Apply means testing to eliminate DSH and ICP funding for hospitals that are highly profitable and do not serve significant numbers of uninsured and Medicaid patients.

NYSNA's positions in support of these position are more fully presented in the attached "NYSNA Recommendations" dated November 9, 2018 and presented to the Indigent Care Workgroup convened by the State of New York. We are hereby attaching that document as part of our testimony for the record.

We urge the Council to take action at the local level and to fully assert the City's interests in ongoing efforts at the State level to enact legislation to fix charity care funding and ensure that NYC Health + Hospitals is fully and fairly funded in proportion to the role it plays as a provider of vital health services.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Indigent Care Pool Workgroup

NYSNA Recommendations **November 9, 2018**

1. Eliminate the Transition Collar

NYSNA has reviewed the various proposal to eliminate the "transition collar." Each proposal raises serious concerns about the impact on Enhanced Safety Net Hospitals ("ESN", as defined in PHL 28000000) and on other hospitals that play safety net roles in their communities but don't meet all of the statutory criteria to qualify as ESN hospitals.

NYSNA has reviewed the NYCHH/Community proposal to eliminate the collar by increasing the Medicaid reimbursement rates for ESN hospitals, shifting $300 million from the DSH/ICP pools to pay the local share, and use various other tools to insulate ESH and near-ESN hospitals from the impact of removing the transition collar.

NYSNA particularly supports the use of tiers in the distribution of ICP/DSH monies and increased Medicaid reimbursement for ESN hospitals.

NYSNA accordingly supports the NYCHH/Community model and the inclusion of that proposal in the final workgroup report.

If the final report does not include that recommendation, NYSNA would request that this proposal be included in the final report as a "minority" recommendation to be considered by the state legislature.

2. Increase Medicaid Reimbursement Rates for Enhanced Safety Net Hospitals by 10%[1]

Pursuant to PHL Section 2807-c(34), subsection (b), the DOH shall, "within amounts appropriated" "adjust medical assistance rates" for Enhanced Safety Net Hospitals. Subsection (c) further provides that "payments made pursuant to this subdivision may be added to rates of payment or made as aggregate payments to eligible general hospitals."

[1] It appears that the State of New York is proposing to increase the Medicaid reimbursement rates for all or some hospitals by 2%. NYSNA supports the proposed general increase in reimbursement rates. The NYSNA proposal to provide ESN hospitals with an additional 10% rate increase bonus would be on top of or in addition to any general rate increase that is carried out by the State.

It is thus the clearly expressed policy of the state New York, pursuant to PHL Section 2807-c to designate a category of hospitals as "enhanced" safety net facilities and to prioritize their support by providing extra or additional monetary support that is to be exclusively available to them. It is further the policy purpose of CMS and the Federal government, supported by the State, to provide additional support and funding through the DSH program to those hospitals that carry a "disproportionate" share of the burden of caring for Medicaid and uninsured patients. It follows, accordingly, that NY State is obligated to give its highest priority to supporting this class of hospitals consistent with both federal and state law and regulation by targeting DSH and ICP funds to support these hospitals.

Accordingly, all hospitals meeting the statutory criteria for classification as "Enhanced Safety Net Hospitals" (ESNs) set forth in PHL Section 2807-c(34) will receive a bonus of 10% on all Medicaid Fee-For-Service and Managed Care In-Patient and Out-Patient rates.

The 71 ESNs include (a) all public hospitals, (b) designated sole community hospitals, (c) designated critical access hospitals, and (d) private voluntary hospitals that meet the definitional criteria based on their disproportionate shares of Medicaid and uninsured patients.[2]

Based on data from the 2013 DSH Audits posted on the CMS website, the total Medicaid reimbursements for these hospitals totaled $7.198 billion. This figure includes in-patient and out-patient reimbursements on a fee-for-service and managed care basis.

Providing these hospitals with a 10% reimbursement bonus would increase their total Medicaid reimbursements by approximately $719.9 million.[3]

Payment of the 10% reimbursement bonus to the ESN hospitals would occur *prior* to the application of DSH and ICP pool distributions.

If possible, the 10% reimbursement bonus should be paid out from Medicaid funding outside of the federal DSH pool. This would allow an increase of federal Medicaid funding for New York hospitals without requiring use of DSH moneys, leaving more for distribution through the pools. The State DOH should accordingly explore this possibility.

If it is not possible to obtain the funding for the 10% reimbursement bonus from Medicaid directly, or if the application of the bonus would require increased state or local contributions in violation of the current global Medicaid Cap, then the funding of the state FMAP share can be effected by transferring the necessary matching funds from the available DSH and ICP pools. Assuming a 50% FMAP share, this would require the use of approximately $360 million from the ICP pool and IGTs to fund this obligation.

The application of the 10% Medicaid rate reimbursement bonus to the ESNs before distribution of DSH/ICP funding will not result in any of the ESN hospitals exceeding their DSH caps. These hospitals, however, will come significantly closer to their DSH caps *before* the application of the various DSH/ICP

[2] The 71 ESN hospitals include 20 public hospitals, and 51 SCH, CAH and private voluntary hospitals out of a total of about 180 hospitals in NY State.

[3] Using more updated DSH data would likely increase this amount somewhat, perhaps to the $750-$800 range. For the purposes of this proposal, however, the 2013 Audited DSH data is sufficient to illustrate the effect of increasing reimbursement rates for ESN hospitals by 10%. It should also be noted that two hospitals from the current ESN list, Bellevue (in Bellevue NY) and Henry J. Carter (part of the NYC Health + Hospitals system) are not included in 10% bonus calculation because they were established after 2013 and thus are not included in the 2013 DSH data.

pool distributions are applied, leaving more funding in the pools to be allocated to other hospitals with higher rates of Medicaid and uninsured patient services.

Finally, it should be noted that the ESN hospitals will still be eligible for additional DSH/ICP disbursements through the pools up to their DSH caps after the application of the reimbursement bonus.

If the 10% bonus can be implemented without use of federal DSH funds, then the state will have increased its draw of federal Medicaid monies. If this is not possible, then the total available pool of DSH funds will remain unchanged (currently about $3.5 billion). The ESNs will merely receive a portion of that funding prior to the distribution of the pool monies.

NYSNA supports the inclusion of this proposal in the final report of the work group. If the final report does not include this recommendation, NYSNA would request that this proposal be included in the final report as a "minority" recommendation to be considered by the state legislature.

3. Change the Priority Order of the Existing ICP/DSH Pools

The current statutory framework for New York State disburses a total of about $3.53 billion to NY hospitals under the federal Disproportionate Share Hospital program. Of this total amount, about $1.8 billion is received from the federal government by NY State to offset hospital unreimbursed costs of caring for Medicaid patients and the uninsured. The remaining $1.8 billion is funded by state or local matching shares, including about $1.1 billion in Indigent Care Pool (ICP) funds raised from various fees and taxes under the HCRA law and about $700 million in "Inter-Governmental Transfers" (IGTs) paid by local governments (most of which comes from the City of New York).

The total DSH disbursement of $3.53 billion DSH funding is distributed to hospitals through five major pools that are defined by State law (see PHL 2807-k), and are paid in the following order:

Step 1	**Voluntary and Non-Major Public ICP Pool: $656 million ICP and $339 million UPL = $995 million**	**Public Indigent Care Pool: $139 million**	**Indigent Care Adjustment Pool: Public Hospitals $412 million**	**Total Step 1 ICP/DSH Funding Fixed by State Law: $1.546 billion**
Step 2	**Non-Health + Hospitals Public Pool (to DSH Cap): +/-$1.2 billion**			**+/- $1.2 billion**
Step 3	**Health + Hospitals "Residual Pool" (to DSH Cap): Remaining Funds After Steps 1 & 2: +/- $1.2 billion**			**+/- $1.2 billion**
Total 2018				**$3.864 billion ($3.525 billion DSH + $339 million UPL)**

Under this framework, the NYC Health + Hospitals system relies for the bulk of its share of federal DSH funding on the residual (or "leftover") pool which contains only funds that remain unspent *after* payments have been made to the Voluntary and other public hospitals in Steps 1 and 2.

This structure has several serious down-sides for NYCHH, which ranks among the highest providers of care to Medicaid and uninsured patients of any hospital system in the state and has one of the lowest levels of privately insured patients. This unfavorable payer mix structurally guarantees that NYCHH will operate at a loss and makes DSH funding vital to its ability to continue to serve its disproportionately large Medicaid and uninsured patient population.

The current structure of the pools creates a situation in which NYCHH is never certain as to the amount that it will receive in any given year. The final amount of funding is subject to changes in the distribution of funding to other hospitals, variations in payer mix or volume of services, variations in the DSH caps of other hospitals, or changes in federal funding levels.

In addition, the timing of NYCHH funding is subject to time lags because NYCHH funding determinations are made on an annual or quarterly basis.

Finally, and most importantly, the placement of NYCHH in a "residual pool" creates a potentially catastrophic result in the event that the federal government implements existing statutory requirements to substantially reduce federal DSH funding to NY and other states. The way in which the pool structure is set up means that, though NYCHH receives the bulk of its DSH allotments from the last pool, any cuts in DSH funding will be taken from the "residual pool" before any other pools are affected. The Voluntary and Non-Major Public hospital pools in Steps 1 and 2 of the DSH funding flow are fixed by law and the amounts in those pools will not immediately change if there are cuts in Medicaid DSH funding.[4]

NYCHH bears the heaviest and most disproportionate share of the costs of uncompensated care for Medicaid and uninsured patients. It is unacceptable that it will be the only hospital system that will face DSH reductions in the event that the planned federal DSH cuts are implemented.[5]

Accordingly, we propose, without changing the current DSH/ICP pool structure or amounts, to shift NYCHH's "Residual Pool" from Step 3 to Step 2 and to move the Voluntary and Non-Major Public Indigent Care Pool to Step 3 in the priority of funding as follows:

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[4] The DSH cuts would first apply to the residual pool and only when the cuts exceed the amounts in that pool will the DSH reductions "flow up" to the higher order pools. Depending on how the DSH cuts are implemented, NYCHH could see an immediate cut of $400 million to $700 million in the first year, with the NYCHH residual pool being drained entirely within a few years. Only after the NYCHH pool is completely drained would the other pools be affected.

[5] It should also be noted, in light of current federal efforts to change "public charge" definitions in a manner that would include Medicaid use as a negative factor in determining whether to approve immigrant applications for a change or upgrade in their current immigration status. If implemented this change in immigration law will result in a large spike in uninsured patient care costs for NYCHH and other safety net hospitals as large numbers of currently insured immigrants withdraw from or avoid Medicaid enrollment to maintain their permanent resident status or seek citizenship. This will hit the NYCHH system particularly hard.

Step 1	Public Indigent Care Pool – $139 million	Indigent Care Adjustment Pool – Public Hospitals $412 million
Step 2	Non-Health + Hospitals Public Pool (to DSH Cap): +/-$1.2 billion	Health + Hospitals Pool (to max. hospital DSH Caps): All residual DSH funds not distributed in Step 1, with local share paid by IGT)
Step 3	Voluntary and Non-Major Public ICP Pool – Up to $656 million ICP and $339 million UPL = $995 million total or such residual funds as remain after Steps 1 and 2)	
Total		No Change From Current Total Funds: About $3.53 billion

The recommended reordering of the priority of DSH pools would not change the current total available funding of $3.53 billion (including current federal DSH allocation, ICP funds or IGT amounts).

The current structure and procedures for distributing funds in each pool would also remain largely unchanged, but any future reductions to DSH funding would be distributed more broadly and equally among the much wider group of voluntary and non-major public hospitals.

To ensure that no DSH money is "left on the table" the current legislative structure should be amended to reorder the pool priorities as indicated above.

In addition, to ensure that no federal DSH money is lost, current law should be amended to allow DSH and ICP funds that are not expended in any pool (due to DSH caps or other factors) to be rolled into the next pool.

Finally, in implementing the above change in pool priority, any regulatory or statutory changes should also consider the effect of implementing the 10% bonus reimbursement for ESN hospitals as discussed in point 1 above.

If the 10% bonus is implemented through use of DSH (and ICP and IGT transfers), then the DSH pool funds allocated to the pools would be reduced by roughly $750 million. This would not mean a full $750 million reduction in the total pool funds because the application of the 10% bonus would merely move the public hospitals to their DSH cap sooner, leaving them with less money to claim from the various public DSH pools.

Any unused monies in those pools (after the public hospitals have reached their DSH caps) would then flow down into the lower pools. With respect to the voluntary ESN hospitals, the 10% bonus would

mean they will end up drawing more than they currently do, so there will be some reductions in the amounts that end up in the lower pools.[6]

4. Create Tiers of Hospitals within the ICP Voluntary and Non-Major Public Pool

As noted in point 1 above, the purpose of the federal DSH program is to provide additional support and financial assistance to those hospitals that provide a "disproportionate" share of caring for Medicaid and uninsured patients. The program is not intended to serve as a broadly and evenly applied reimbursement of unpaid patient care costs distributed to all hospitals on an equal procedure-for-procedure or service-for-service basis. The built in programmatic assumption is that DSH funding is targeted to those hospitals that provide the most uncompensated care as a share of their total patient care. It thus follows that DSH funding should prioritize and be concentrated on those "disproportionate share" hospitals.

The current structure of DSH/ICP funding and distribution does provide somewhat higher funding to hospitals with higher Medicaid and uninsured patient levels, but it still give too high a share to hospitals that don't meet these criteria.

In order to more fairly (and consistently with federal law) distribute DSH and ICP funds, and reduce the inappropriate allocation of money to hospitals that neither needs nor deserve this scarce funding, we recommend that the Voluntary and Non-Major Public ICP pool be modified to distribute money on the basis of specific tiers, with each tier receiving a set percentage of the total pool.

In order to carry out this objective and properly target the funding in this pool, which we assume to be the $995 million that is currently allocated in this year, we would propose creating the following Tiered Allocation system:

	Voluntary and Non-Major Public ICP Pool: $995 million
	Definitions
Tier 1	ESN – Enhanced Safety Net Hospitals as defined in PHL Section 2807-c(34)
Tier 2	Non-ESN Safety Net Hospitals – Uncompensated Medicaid/Uninsured Care Costs as a percentage of Total Costs (Based on DSH Audit Report) above a determined percentage rate.
Tier 3	Remaining Voluntary Hospitals (unless in Tier 4 Excluded Category) – Uncompensated Medicaid/Uninsured Care Costs not meeting the threshold for inclusion in Tier 2.
Tier 4	Excluded Low Medicaid/Uninsured: Any non-ESN Hospital with Uncompensated/Uninsured Care Costs as a percentage of total costs that places them in the bottom 10% of all hospitals.

[6] If we adopt the 10% bonus reimbursement and reordering of the pools as proposed in points 1 and 2 above, the Voluntary and Non-Major Public ICP pool would no longer be guaranteed to receive $995 million. It would in effect become the new "residual pool." In the current year, however, there would be no reduction in the total pool money, since the public hospitals are all expected to receive their full DSH allotment in the current year and any increases in the voluntary ESN allotments would be cost neutral vis a vis the entire pool (the net funding for voluntary hospitals would be the same, $3.52 billion, but the distribution of that amount would change in favor of the ESN hospitals). In future years, however, any reductions in DSH money for New York would impact the total available in the ICP voluntary pool.

Under this proposal to "Tier" hospitals in the Voluntary and Non-Major Public ICP Pool, the following principles and standards would apply:

(a) Within each Tier, all hospitals will receive DSH funding to their hospital-specific DSH cap;

(b) Funds will be distributed based on formulas, as modified in Proposal/Recommendation #4 below, but with the allocation of funds based on the final "Nominal Need" of each hospital divided by the funds available within its particular Tier, rather than the total pool;

(c) All funds within the pool that are unallocated due to operation of the DSH caps for specific hospitals will be reallocated to the remaining hospitals within that Tier, using the same distribution formulas used in the first allocation;

(d) Any remaining unallocated funds in each Tier will flow to the next Tier to be distributed to hospitals within that Tier; and

(e) Each Tier within the pool will receive a set percentage of the available Tier funds. The allocation of funds to each Tier should be determined to provide higher payments to the higher Medicaid/uninsured use hospitals.[7]

5. Change the Formulas for Distribution of ICP Funds In the Voluntary and Non-Major Public Pool to Target Hospitals With the Highest Rates of Medicaid and Uninsured Patients

As noted in NYSNA's October 9, 2018 submission to the Workgroup, the formulas used to determine need and distribute ICP funding are biased in several ways. The use of state-wide average cost adjustments (SWAF) are biased against those hospitals with higher than average costs to the benefit of those with lower costs. In addition, the formulas for calculating the allocations inappropriately distributes money in a manner that benefits lower Medicaid/Uninsured patient care hospitals at the expense of higher Medicaid/Uninsured patient care hospitals. These distortions in the distributions of funding include the following distorting factors in the formulas for calculating nominal need: the use of a 40% floor for all hospitals, failure to include outpatient services as a factor, failure to include uninsured patient care costs, and failure to consider hospital profitability (which is directly linked to such structural factors as patient payer mix and avoidance of low reimbursement services such as psychiatric or emergency services).

[7] For example, Tier 1 could receive 30% of the total pool funds, Tier 2 30% of the total pool funds, Tier 3 40% of the total funds, and Tier 4 0% of the total funds available for the pool. Note that these percentages are for illustrative purposes only. A full costing would have to be carried out to determine and establish in statute an appropriate percentage allocation for each Tier within the Voluntary and Non-Major Public Pool with the goal of allocating funding within the pool to each Tier so that hospitals with the highest Medicaid and Uninsured patient levels receive a greater share of pool funds.

The distribution of ICP funds should accordingly be corrected to remove these imbalances with the following changes in the distribution formulas:

a) **Use Actual Cost Adjustment Instead of Statewide SWAF Average Cost Adjustment In Determining Base Uncompensated Care for the Uninsured**

The current formula for determining ICP distributions starts with the in-patient and out-patient uninsured units of service and multiplies them by the Medicaid rate of reimbursement for each such service to arrive at a base uncompensated care figure.

The in-patient uncompensated care cost for the uninsured is then multiplied by an average Statewide Cost Adjustment Factor (SWAF) of 1.3.

The out-patient uncompensated care cost is multiplied by an average Statewide Cost Adjustment Factor (SWAF) of 1.9.

The formula then produces a "Net Adjusted Uncompensated Care Need" for each hospital. This number is then adjusted again to arrive at the final "Nominal Need" factor that is used to determine each hospital's share of the total ICP pool.

The use of a statewide average SWAF for both in-patient and out-patient costs penalizes hospitals in areas with costs that are above the state average and benefits hospitals in areas with costs below the state average.

Recommendation: Replace the state-wide average SWAF for both in-patient and out-patient cost adjustments with an adjustment factor based on actual cost variations in specific geographic areas or health care markets to create a "Net Adjusted Uncompensated Care Need" that closely tracks actual cost variations in each local market area.

b) **Incorporate Medicaid Inpatient and Outpatient Utilization Rates in the Formula for Arriving at "Nominal Need"**

The current formula for determining the allocation of ICP funds starts with a calculation of "Net Adjusted Uncompensated Care Need" that includes uncompensated Medicaid/uninsured costs for both in-patient and out-patient services.

In determining the "Nominal Need" number that actually determines the allocation of ICP monies, however, the actual uncompensated care costs for each hospital are then adjusted solely on the basis of the percentage of in-patient Medicaid discharges. The final determination of "Nominal Need" (which sets the final allocation of ICP funds) does not consider uncompensated out-patient costs.

This has the effect of skewing the final allocation of ICP funds against hospitals that have large out-patient footprints or that focus more on providing out-patient services to low income populations as opposed to providing specialty out-patient ambulatory services to insured patients.

Recommendation: The determination of "Nominal Need" should factor in out-patient Medicaid patient rates. For example, the "Nominal Need" could be determined by multiplying the "Net Adjust Uncompensated Care Need" by the Medicaid In-Patient utilization rate plus the Medicaid Out-Patient Utilization Rate. In the alternative, the formula could discard in-patient and out-patient utilization rates

and instead use a multiplier derived from the percentage rate of total uncompensated Medicaid/uninsured in-patient and out-patient costs compared to total costs on the DSH audit.

c) Incorporate Uninsured In-Patient and Out-Patient Rates in the Calculation of Nominal Need

As noted in point (b) above, the determination of "Nominal Need" relies exclusively on the Medicaid In-Patient Utilization rate of each hospital. This not only disadvantages hospitals with relatively higher out-patient footprints, it also penalizes hospitals with higher levels of both in-patient and out-patient uninsured losses.

Two hospitals could have the same in-patient Medicaid utilization rates, but one could have a much higher percentage of uninsured patients in both the in-patient and the out-patient settings.

This also skews the distribution of funds to the disadvantage of hospitals with relatively higher ratios of uninsured patients.

Recommendation: The determination of "Nominal Need" should factor in in-patient and out-patient uninsured usage rates. For example, the "Nominal Need" could be determined by multiplying the "Net Adjust Uncompensated Care Need" by the Medicaid IP and OP utilization rates and the Uninsured IP and OP utilization rates. In the alternative, the formula could discard in-patient and out-patient utilization rates and instead use a multiplier derived from the percentage of total uncompensated Medicaid/uninsured in-patient and out-patient costs as compared to total costs on the DSH audit.[8]

d) Remove the 40% Floor In Determining the Nominal Need Factor

The current formula for setting the final "Nominal Need" for each hospital multiplies the Medicaid Inpatient Utilization Rate (MUIR) for each hospital by a fixed and pre-determined 60% and then adds 40% to that number to arrive at the final allocation percentage. That final percentage is then applied to the "Net Adjusted Uncompensated Care Need" to arrive at the "Nominal Need" that will determine the hospital's share of the total pool funding.

This formula introduces a minimum floor of 40% for all hospitals that benefits lower Medicaid/uninsured use hospitals at the expense of higher use hospitals. This floor artificially increases the share of ICP funds distributed to lower use facilities.

For example, a hospital with a 60% MIUR would have its final "nominal need" determined by using a 76% of need adjustment while a 40% MIUR hospitals would have its need adjusted by 64%.[9]

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[8] Note that the use of this alternative – the ratio of total uncompensated care costs as a percentage of total costs (using the DSH audit data) – would incorporate the out-patient usage discussed in point (b) and the uninsured in-patient and out-patient usage discussed in point (c).

[9] Hospital A with a 60% Medicaid in-patient utilization rate would have its nominal need adjusted as follows: (60% MIUR x 60%) + 40% base/floor = 36% +40% = 76%. Hospital B with a 40% Medicaid in-patient utilization rate would have its rate determined as follows: (40% x 60%) + 40% base/floor = 24% + 40% = 64%. Note that if these two hospitals were the entire universe of hospitals receiving ICP funds, Hospital A would get 76/140 of the total amount or 54% and hospital B would get 64/140 of that amount or 46%. If the amounts were distributed without the 40% base/floor and based only on the Medicaid percentage, Hospital A would receive 60% and Hospital B 40%.

Recommendation: Determination of "Nominal Need" should be based solely on the actual rate of Medicaid + Uninsured use, without adding any floor or other adjustments to distort the distribution of funds. This could be implemented by removing the 40% floor/base and using only the actual Medicaid inpatient rate. In the alternative, the formula could discard Medicaid in-patient utilization rate entirely and instead use a multiplier derived from the percentage of total uncompensated Medicaid/uninsured in-patient and out-patient costs as compared to total costs on the DSH audit.

e) Net "Nominal Need" Should be Adjusted to Reduce Allotments To Reflect High Net Revenues, Including Patient Care and Non-Patient Care Revenues

The purpose of DSH/ICP funding is not merely to compensate all hospitals for fulfilling their charitable health care purposes. The main policy goal is to support those hospitals that have the highest rates of Medicaid and uninsured patient care.

The tax funded DSH/ICP pool moneys should accordingly be focused on supporting safety net hospitals. There is no legal or ethical basis for providing taxpayer support to augment the profits/surpluses of already profitable hospitals, especially in a context in which available funding is not sufficient to provide adequate support to vital safety net hospitals that bear a disproportionate share (hence the name of the DSH program) of caring for people who cannot afford to pay for the costs of their care.

Our hospital system is increasingly being segmented into a two-tiered system in which some hospitals disproportionately care for poor, uninsured and underinsured populations and communities, while others increasingly focus on the pursuit of the most profitable patients and service lines.

In this context, many large academic medical centers, with increasingly concentrated ownership and market power, operate with high profits but are still able to collect a large and increasing share of DSH/ICP monies that were not intended for this purpose.

The current ICP distribution formulas thus inappropriately divert ICP funding to these hospitals at the expense of hospitals that face structural financial losses because of the payer mixes with the highest levels of Medicaid and uninsured patient populations and relatively low privately insured patient rates.

These large and profitable hospitals thus generate significant surpluses/profits because of a lower relative share of Medicaid and uninsured patients and a higher mix of privately insured patients, while simultaneously serving large absolute numbers of Medicaid and uninsured patients. Because of their high volume, they receive a large share of ICP funding allocations, even though their share of Medicaid and uninsured patients is low relative to their total revenues.[10]

[10] The same dynamic also plays out in the case of smaller community hospitals that are located in or primarily serve high income local markets.

This is illustrated in the following chart using a few major hospitals as examples:

2016 Financials	NY Presbyterian	NYU Langone	Mt. Sinai	Northwell
Revenue	$7,421,079,000	$3,582,121,000	$2,368,257,000	$9,938,268,000
Costs	$7,096,220,000	$3,303,731,000	$2,208,521,000	$9,842,401,000
Net Profit	$324,859,000	$278,390,000	$159,736,000	$95,867,000
Profit %	4.58%	8.43%	7.23%	0.97%
2018 ICP	$61,861,063	$50,631,962	$40,220,144	$21,653,526

In the above examples, these four large systems generated net profits of almost $860 million, but were able to draw down more than $170 million in ICP pool funding (more than 1/5th of the entire pool).

There is no discernible rationale why these and other highly profitable hospitals should be drawing such a significant portion of ICP/DSH funding.

Recommendation 1:

The formula for determining "Nominal Need" should be further modified to account for hospital profits and losses, which correlate to the structural effects of hospital payer mixes.

Accordingly, the final "Nominal Need" factor should have an additional step in which each hospital's nominal need percentage factor is adjusted by the profit or loss rate. The profit/loss rate should be based on total hospital revenue, including (a) all reimbursements and other grants or payments received for patient care and (b) all non-patient care or operating revenue, including returns from investments and private donations to operating and capital budgets.

For example, if Hospital A and Hospital B both have final nominal need factor adjustment percentages of 60%, but Hospital A has a 5% net surplus/profit and Hospital B has a 5% net loss, then the final adjustment percentage of hospital A would be reduced by 5% to 55% and that of Hospital B would be increased by 5% to 65%.

In the case of the four hospital systems cited above, each would have its final ICP allotment (if any) reduced by the amount of their respective profit/surplus rates.

Recommendation 2:

The final distribution of ICP funds, after all adjustments discussed above, should be further subject to an absolute reduction equal to the amount of any profits/surpluses in excess of a standard cap of 3%. This would deduct from ICP allotments the amounts of net profits/surpluses of each hospitals (defined as the excess of patient care and non-patient care revenues over costs) that exceed 3% of total costs.

All gross revenue in excess of the 3% cap would be deducted, dollar for dollar, against any ICP allotment that has been determined by application of the distribution formulas.

This would have the following illustrative effect on the four hospital systems used in our example:[11]

2016 Financials	NY Presbyterian	NYU Langone	Mt. Sinai	Northwell
Revenue	$7,421,079,000	$3,582,121,000	$2,368,257,000	$9,938,268,000
Costs	$7,096,220,000	$3,303,731,000	$2,208,521,000	$9,842,401,000
Net Profit	$324,859,000	$278,390,000	$159,736,000	$95,867,000
Profit %	4.58%	8.43%	7.23%	0.97%
3% Limit/Cap	$212,886,600	$99,111,930	$66,255,630	$295,272,030
Profit in Excess (>3%)	$111,972,400	$179,278,070	$93,480,370	None
2018 ICP	$61,861,063	$50,631,962	$40,220,144	$21,653,526
ICP Reduction	($61,861,063)	($50,631,962)	($40,220,144)	None
Final ICP Payment	None	None	None	$21,653,526

6. Fully and Uniformly Enforce the Hospital Financial Assistance Law

New York State requires hospitals to provide charity care to uninsured and underinsured patients under the Hospital Financial Assistance Law (HFAL - PHL §2807-k(9-a)). This takes the form of free or reduced charges for care based on sliding scales and ability to pay.

In implementing the law, however, each hospital currently creates its own policies and procedures for receiving assistance. This has resulted in a wide range of policies and practices that raise questions about overall compliance with the letter and intent of the law.

Recommendation 1:

Adopt a single uniform statewide financial assistance application and other materials to be used by all hospitals.

Recommendation 2:

The DOH should perform audits of all elements of hospital compliance and impose meaningful penalties for failure to comply.

[11] Note that these calculations are based on existing DSH/ICP distribution formulas. If the other recommendation proposed by NYSNA were to be implemented, the allotments of funds to these hospitals would be significantly smaller.

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New York City Council - Committee on Hospitals

January 16, 2019 Oversight Hearing

Re: Charity Care Funding for New York City Hospitals

Testimony of Anne Bove, RN, NYSNA Board of Directors

Chairperson Rivera and Members of the Committee on Hospitals,

I would like to thank you for giving me the opportunity to testify before you this afternoon on the issue of Charity Care Funding for New York City Hospitals.

My name is Anne Bove. I was a front line nurse employed by the New York City Health + Hospitals system. I recently retired after working for almost four decades at Bellevue Hospital Center, the oldest public hospital in the country and one of the core hospitals of the public Health + Hospitals system.

Profitable Private Hospital Networks Exploit Health + Hospitals and Safety-Net Hospitals

Health + Hospitals is not only a vital safety-net hospital that provides health care to the uninsured, underinsured and underserved communities, it is also the backbone of the entire public and private health care system in the City of New York.

Health + Hospitals provides free health care to about 400,000 uninsured New Yorkers and accounts for about 20% of inpatient hospital care and an even higher percentage of outpatient and primary care clinic services in NY City. In addition, it must be noted that Health + Hospitals provides a disproportionate share of expensive and poorly compensated Level I trauma services, in-patient and out-patient psychiatric services, and a range of other vital health care services that private sector hospitals avoid because simply because they are unprofitable and they can.

Because NYC Health + Hospitals is there to pick up the costs of caring for the uninsured and providing these poorly compensated services, the large private hospital networks are able to focus on more profitable lines of health care services that pad their bottom lines and leave the public hospitals and other safety-net providers to deal with the financial losses of providing that vital and necessary care.

The result is that NYC Health + Hospitals and other safety-net providers are set up to lose money so that the big private hospital systems can generate huge profits.

This symbiotic financial relationship between NYC Health + Hospitals and the big private hospital networks is readily apparent when we compare their financial positions. NYC Health + Hospitals loses more than $1 billion a year on patient care operations and relies on direct subsidies from the City of New York to maintain operations. The big private hospital systems, by way of contrast, earned

hundreds of millions in profits by focusing their activities on wealthier patients with good private insurance and profitable services like joint surgeries, cardiac care and cancer treatments. Thus, in 2016 NYU Langone reported net profits of $278 million, NY Presbyterian reported $324 million, Northwell reported $95 million, and Mount Sinai reported $159 million, all while NYCHH faced operating losses of about $1.1 billion. The connection between the precarious financial status of safety-net hospitals and the big private networks is pretty obvious.

Charity Care Funding In New York State Is Broken

New York hospitals are legally obligated to provide health services to patients based on their ability to pay. The Federal EMTALA regulations require hospitals to provide emergency treatment to all patients even if they cannot pay, but do not require follow-up or ongoing medical service be provided outside of the emergency room. In addition the State Hospital Financial Assistance Law (HFAL) requires hospitals to provide care in the form of zero or reduced charges based on sliding scales and the patient's ability to pay. In practice, many private hospitals shirk their obligations under these laws while NYC Health + Hospitals turns no patients away whether they can pay or not – it is no accident that the public system cares for a disproportionate share of uninsured and underinsured patients despite these laws being on the books. The dynamic at play is, again, obvious and does not require much more explaining.

The costs of caring for the uninsured and the underinsured are supposed to be at least partially compensated through the funding provided by the Federal Disproportionate Share Hospital (DSH) program. Recognizing that hospitals that *disproportionately* care for Medicaid and uninsured patients will necessarily lose money on their operations while hospitals that have higher percentages of privately insured patient and fewer uninsured will make money, the Federal DSH program distributes extra funding to the states to fix this problem.

The underlying premise of the federal DSH program is that Medicaid rates are not sufficient to cover hospital costs and provide little reimbursement to hospitals for their uninsured patients. This means that hospitals with high rates of Medicaid and uninsured patients and low rates of privately insured patients are structurally guaranteed to lose money. To keep these vital safety net hospitals from closing or slashing needed services, the federal government provides DSH funding to offset these structural losses.

New York currently receives about $1.8 billion in federal DSH funding per year. This must be matched by a corresponding $1.8 billion in state and local matching funds (the so-called FMAP or state share, which for New York is 50%). This combined pool of $3.6 billion is then distributed to hospitals to make up for their uncompensated patient care costs.

Under the DSH program each state has the authority to decide on exactly how the total pool of money is distributed to its hospitals. In New York, the $1.8 billion of the local share of the total DSH funds is mostly paid for from what is known as the "Indigent Care Pool" or ICP. The ICP is generated from state Health Care Reform Act (HCRA) taxes and fees that amount to about $1.13 billion. The remaining $700 million in local share DSH funds is paid directly through "Inter-Governmental Transfers" (IGTs) by localities, with most of that money being paid by the City of New York as the local share of the NYC Health + Hospitals DSH allocation (thus NYC H + H receives about $1.4 billion in DSH money, half of which comes from the Federal government and half from the City of New York).

Historically the NY state DSH and ICP program has been plagued by structural problems that created inequities in the way in which the federal DSH allotments and the local ICP share monies are distributed.

This results in a short changing of safety net hospitals that shoulder a disproportionate share of "charity care" and gives inordinate amounts of money to hospitals that do not need or deserve the funding they receive. In short charity care funding is not being targeted to help keep safety net hospitals operating and is enriching already well compensated private hospital networks.

Thus, we find that NYU Langone, for example, which made $278 million in profits in 2016 and continues to make huge profits, is expected to receive $50.6 million in ICP charity car funding in 2018, and NY Presbyterian, which generated $324 million in profits is expected to receive $61 million. To provide these immensely profitable hospitals with tens of millions of funding when real safety net hospitals are under laboring to provide vital services under severe financial strain is unconscionable.

This system is broken and it needs to be fixed.

Charity Care Funding Under DSH and the ICP Improperly Compensates Hospitals for "Bad Debt" Costs

The State DSH and ICP program have allowed hospitals to mix true indigent care costs (i.e., losses arising from caring for poor people who were uninsured or could not otherwise pay for the cost of their care) with bad debt losses (i.e., hospital costs that insured or well off patients refused to pay, such as co-payments or uncovered elective services).

Charity care constitutes losses by hospitals for providing free or reduced charge care to those who could not pay, and such services are a real loss. Bad debt on the other hand, reflected a failure to pay full charges, even though the hospital may have received payments that equal or exceed costs, and they are merely failing to fully collect the list-price amount that was charged. In this case, hospitals can still make a profit on providing care to the privately insured patient *and also receive ICP and DSH payments for these "losses."*

With the passage of the ACA, states were required to stop counting bad debt as charity care. New York State implemented a statutory change in 2012 to phase out the inclusion of bad debt in the distribution of DSH/ICP funds. As part of this phase out process, the state created a "transition collar" that would reduce hospitals' DSH funding by slowly phasing out bad debt from the calculation of charity care pool funding at the rate of 2.5% per year. This would allow hospitals a period of three years to "wean" themselves of improper bad debt payments. The "transition collar", however, was supposed to last only for three years, after which bad debt would no longer be used in DSH/ICP payment calculations. That timeline however keeps getting suspended, and the "transition collar" continues to allow hospitals to receive payments for their "bad debt." This not only raises questions about whether NY state is in violation of federal law and/or liable for penalties or other enforcement actions that could have serious repercussions for NY state's DSH funding and for NY hospitals, but also allows hospitals that are otherwise profitable to continue to receive DSH and ICP funding they do not deserve. This leaves less money for true safety-net hospitals.

DSH and the ICP Funding Is Not Targeted to "Disproportionate Share Hospitals"

State DSH/ICP funds are not sufficiently targeted to hospitals that provide a "disproportionate" share of Medicaid and uninsured patient care. The formulas that NY uses allocate and disperse the DSH funds in a broader manner to all hospitals instead of targeting it to those that most need it. In effect, though NY state DSH/ICP disbursement and allocation formulas do give some hospitals slightly more than others, in its essence the program as currently structured continues to provide reimbursement to all hospitals for

the losses incurred in treating Medicaid and uninsured patients, even if those hospitals generated profits from a favorable patient payer mix with high percentages of privately insured patients.

The distribution of DSH and ICP funds should be disproportionately targeted to NYC Health + Hospitals and other safety net hospitals that have the highest numbers of uninsured and Medicaid patients and the lowest numbers of wealthy and privately insured patients.

NYC Health + Hospitals Will Bear Sole Cost of DSH Cuts Scheduled to Take Effect in FY2020

The state DSH and ICP allocation formulas are set by state law and move the $3.8 billion in federal and local matching funds through a series of distribution pools. The way these pools are set up creates a final "leftover" or residual pool through which NYC Health + Hospitals receives most of its DSH funding. The NYCHH residual pool gets whatever is left after all of the earlier DSH pools are distributed and spent.

This statutory structure creates two critical problems for the NYCHH system – first it never knows with certainty how much money it will receive in any given year, and second it leaves NYCHH exposed to bearing the entire brunt of any cuts in federal DSH funding.

This second problem has become particularly in the aftermath of passage of the ACA. The ACA significantly reduced the total numbers of uninsured patients, and based on this working assumption, it called for the phasing out of DSH payments over a multi-year time frame. Though the legislated DSH cuts have been delayed several times, if there is no change in current law, significant reductions in DSH are scheduled to resume in 2019 and continue to escalate. Under the current DSH/ICP structure, *all DSH cuts will come out of the NYCHH residual pool. NYCHH will bear the full brunt of the cuts before any other hospitals are affected. It is estimated that NY State will lose up to $700 million in DSH funding in FY 2020, and all of this cut will come out of NY Health + Hospitals if there is no change in state law.*

NYSNA Fully Supports the "H + H Community Proposal" To Eliminate the Transition Collar, Target Funding to True Safety Net Hospitals, and Increase Total NY State Hospital Funding

The immediate removal of the DSH/ICP "Transition Collar" would significantly reduce funding for hospitals that do not serve a disproportionate share of Medicaid and indigent patients. It would, however, also harm some hospitals defined as "Enhanced Safety Net Hospitals" under state law and others that play vital safety net roles even though they do not meet all of the statutory criteria to qualify as ESN hospitals.

The "H+H Community Proposal" would immediately eliminate the transition collar by increasing the Medicaid reimbursement rates for Enhanced Safety Net hospitals, shifting $300 million from the DSH/ICP pools to pay the 50% local share of the increased reimbursement rates, and use various other tools to insulate ESH and near-ESN hospitals from the impact of removing the transition collar.

NYSNA particularly supports the use of tiers in the distribution of ICP/DSH monies and increased Medicaid reimbursement for ESN hospitals.

NYSNA accordingly supports the H+H Community model for the reasons that were more fully addressed by the testimony of Health + Hospitals and other supporters of the proposal.

In Addition, NYSNA Supports the Following Additional Measures to Direct Funding to Safety Net Hospitals and Reduce Funding for Profitable Hospitals That Neither Need nor Deserve DSH/ICP Funds

- Increase Medicaid reimbursement rate for all hospitals meeting the definition of Enhance Safety Net Hospitals under PHL Section 2807-c(34);
- Immediately change the priority order for distribution of DSH and ICP fund pools to remove Health + Hospitals from the "residual" or "leftover" pool that will bear the full and sole brunt of any future reductions in Federal DSH funding.
- Create Tiers of Hospitals with the ICP Voluntary Pool based on safety net status to redirect the $1.135 billion in that pool to true safety net hospitals and to eliminate funding for hospitals with low levels of Medicaid and uninsured patient or high profits.
- Change the technical formulas for distribution of ICP funds to target pool allocation to hospitals within the pool with the highest level of Medicaid and uninsured patients.
- Apply means testing to eliminate DSH and ICP funding for hospitals that are highly profitable and do not serve significant numbers of uninsured and Medicaid patients.

NYSNA's positions in support of these position are more fully presented in the attached "NYSNA Recommendations" dated November 9, 2018 and presented to the Indigent Care Workgroup convened by the State of New York. We are hereby attaching that document as part of our testimony for the record.

We urge the Council to take action at the local level and to fully assert the City's interests in ongoing efforts at the State level to enact legislation to fix charity care funding and ensure that NYC Health + Hospitals is fully and fairly funded in proportion to the role it plays as a provider of vital health services.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Indigent Care Pool Workgroup

NYSNA Recommendations **November 9, 2018**

1. Eliminate the Transition Collar

NYSNA has reviewed the various proposal to eliminate the "transition collar." Each proposal raises serious concerns about the impact on Enhanced Safety Net Hospitals ("ESN", as defined in PHL 28000000) and on other hospitals that play safety net roles in their communities but don't meet all of the statutory criteria to qualify as ESN hospitals.

NYSNA has reviewed the NYCHH/Community proposal to eliminate the collar by increasing the Medicaid reimbursement rates for ESN hospitals, shifting $300 million from the DSH/ICP pools to pay the local share, and use various other tools to insulate ESH and near-ESN hospitals from the impact of removing the transition collar.

NYSNA particularly supports the use of tiers in the distribution of ICP/DSH monies and increased Medicaid reimbursement for ESN hospitals.

NYSNA accordingly supports the NYCHH/Community model and the inclusion of that proposal in the final workgroup report.

If the final report does not include that recommendation, NYSNA would request that this proposal be included in the final report as a "minority" recommendation to be considered by the state legislature.

2. Increase Medicaid Reimbursement Rates for Enhanced Safety Net Hospitals by 10%[1]

Pursuant to PHL Section 2807-c(34), subsection (b), the DOH shall, "within amounts appropriated" "adjust medical assistance rates" for Enhanced Safety Net Hospitals. Subsection (c) further provides that "payments made pursuant to this subdivision may be added to rates of payment or made as aggregate payments to eligible general hospitals."

[1] It appears that the State of New York is proposing to increase the Medicaid reimbursement rates for all or some hospitals by 2%. NYSNA supports the proposed general increase in reimbursement rates. The NYSNA proposal to provide ESN hospitals with an additional 10% rate increase bonus would be on top of or in addition to any general rate increase that is carried out by the State.

It is thus the clearly expressed policy of the state New York, pursuant to PHL Section 2807-c to designate a category of hospitals as "enhanced" safety net facilities and to prioritize their support by providing extra or additional monetary support that is to be exclusively available to them. It is further the policy purpose of CMS and the Federal government, supported by the State, to provide additional support and funding through the DSH program to those hospitals that carry a "disproportionate" share of the burden of caring for Medicaid and uninsured patients. It follows, accordingly, that NY State is obligated to give its highest priority to supporting this class of hospitals consistent with both federal and state law and regulation by targeting DSH and ICP funds to support these hospitals.

Accordingly, all hospitals meeting the statutory criteria for classification as "Enhanced Safety Net Hospitals" (ESNs) set forth in PHL Section 2807-c(34) will receive a bonus of 10% on all Medicaid Fee-For-Service and Managed Care In-Patient and Out-Patient rates.

The 71 ESNs include (a) all public hospitals, (b) designated sole community hospitals, (c) designated critical access hospitals, and (d) private voluntary hospitals that meet the definitional criteria based on their disproportionate shares of Medicaid and uninsured patients.[2]

Based on data from the 2013 DSH Audits posted on the CMS website, the total Medicaid reimbursements for these hospitals totaled $7.198 billion. This figure includes in-patient and out-patient reimbursements on a fee-for-service and managed care basis.

Providing these hospitals with a 10% reimbursement bonus would increase their total Medicaid reimbursements by approximately $719.9 million.[3]

Payment of the 10% reimbursement bonus to the ESN hospitals would occur *prior* to the application of DSH and ICP pool distributions.

If possible, the 10% reimbursement bonus should be paid out from Medicaid funding outside of the federal DSH pool. This would allow an increase of federal Medicaid funding for New York hospitals without requiring use of DSH moneys, leaving more for distribution through the pools. The State DOH should accordingly explore this possibility.

If it is not possible to obtain the funding for the 10% reimbursement bonus from Medicaid directly, or if the application of the bonus would require increased state or local contributions in violation of the current global Medicaid Cap, then the funding of the state FMAP share can be effected by transferring the necessary matching funds from the available DSH and ICP pools. Assuming a 50% FMAP share, this would require the use of approximately $360 million from the ICP pool and IGTs to fund this obligation.

The application of the 10% Medicaid rate reimbursement bonus to the ESNs before distribution of DSH/ICP funding will not result in any of the ESN hospitals exceeding their DSH caps. These hospitals, however, will come significantly closer to their DSH caps *before* the application of the various DSH/ICP

[2] The 71 ESN hospitals include 20 public hospitals, and 51 SCH, CAH and private voluntary hospitals out of a total of about 180 hospitals in NY State.

[3] Using more updated DSH data would likely increase this amount somewhat, perhaps to the $750-$800 range. For the purposes of this proposal, however, the 2013 Audited DSH data is sufficient to illustrate the effect of increasing reimbursement rates for ESN hospitals by 10%. It should also be noted that two hospitals from the current ESN list, Bellevue (in Bellevue NY) and Henry J. Carter (part of the NYC Health + Hospitals system) are not included in 10% bonus calculation because they were established after 2013 and thus are not included in the 2013 DSH data.

pool distributions are applied, leaving more funding in the pools to be allocated to other hospitals with higher rates of Medicaid and uninsured patient services.

Finally, it should be noted that the ESN hospitals will still be eligible for additional DSH/ICP disbursements through the pools up to their DSH caps after the application of the reimbursement bonus.

If the 10% bonus can be implemented without use of federal DSH funds, then the state will have increased its draw of federal Medicaid monies. If this is not possible, then the total available pool of DSH funds will remain unchanged (currently about $3.5 billion). The ESNs will merely receive a portion of that funding prior to the distribution of the pool monies.

NYSNA supports the inclusion of this proposal in the final report of the work group. If the final report does not include this recommendation, NYSNA would request that this proposal be included in the final report as a "minority" recommendation to be considered by the state legislature.

3. Change the Priority Order of the Existing ICP/DSH Pools

The current statutory framework for New York State disburses a total of about $3.53 billion to NY hospitals under the federal Disproportionate Share Hospital program. Of this total amount, about $1.8 billion is received from the federal government by NY State to offset hospital unreimbursed costs of caring for Medicaid patients and the uninsured. The remaining $1.8 billion is funded by state or local matching shares, including about $1.1 billion in Indigent Care Pool (ICP) funds raised from various fees and taxes under the HCRA law and about $700 million in "Inter-Governmental Transfers" (IGTs) paid by local governments (most of which comes from the City of New York).

The total DSH disbursement of $3.53 billion DSH funding is distributed to hospitals through five major pools that are defined by State law (see PHL 2807-k), and are paid in the following order:

Step 1	**Voluntary and Non-Major Public ICP Pool: $656 million ICP and $339 million UPL = $995 million**	**Public Indigent Care Pool: $139 million**	**Indigent Care Adjustment Pool: Public Hospitals $412 million**	**Total Step 1 ICP/DSH Funding Fixed by State Law: $1.546 billion**
Step 2	**Non-Health + Hospitals Public Pool (to DSH Cap): +/-$1.2 billion**			**+/- $1.2 billion**
Step 3	**Health + Hospitals "Residual Pool" (to DSH Cap): Remaining Funds After Steps 1 & 2: +/- $1.2 billion**			**+/- $1.2 billion**
Total 2018				**$3.864 billion ($3.525 billion DSH + $339 million UPL)**

Under this framework, the NYC Health + Hospitals system relies for the bulk of its share of federal DSH funding on the residual (or "leftover") pool which contains only funds that remain unspent *after* payments have been made to the Voluntary and other public hospitals in Steps 1 and 2.

This structure has several serious down-sides for NYCHH, which ranks among the highest providers of care to Medicaid and uninsured patients of any hospital system in the state and has one of the lowest levels of privately insured patients. This unfavorable payer mix structurally guarantees that NYCHH will operate at a loss and makes DSH funding vital to its ability to continue to serve its disproportionately large Medicaid and uninsured patient population.

The current structure of the pools creates a situation in which NYCHH is never certain as to the amount that it will receive in any given year. The final amount of funding is subject to changes in the distribution of funding to other hospitals, variations in payer mix or volume of services, variations in the DSH caps of other hospitals, or changes in federal funding levels.

In addition, the timing of NYCHH funding is subject to time lags because NYCHH funding determinations are made on an annual or quarterly basis.

Finally, and most importantly, the placement of NYCHH in a "residual pool" creates a potentially catastrophic result in the event that the federal government implements existing statutory requirements to substantially reduce federal DSH funding to NY and other states. The way in which the pool structure is set up means that, though NYCHH receives the bulk of its DSH allotments from the last pool, any cuts in DSH funding will be taken from the "residual pool" before any other pools are affected. The Voluntary and Non-Major Public hospital pools in Steps 1 and 2 of the DSH funding flow are fixed by law and the amounts in those pools will not immediately change if there are cuts in Medicaid DSH funding.[4]

NYCHH bears the heaviest and most disproportionate share of the costs of uncompensated care for Medicaid and uninsured patients. It is unacceptable that it will be the only hospital system that will face DSH reductions in the event that the planned federal DSH cuts are implemented.[5]

Accordingly, we propose, without changing the current DSH/ICP pool structure or amounts, to shift NYCHH's "Residual Pool" from Step 3 to Step 2 and to move the Voluntary and Non-Major Public Indigent Care Pool to Step 3 in the priority of funding as follows:

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[4] The DSH cuts would first apply to the residual pool and only when the cuts exceed the amounts in that pool will the DSH reductions "flow up" to the higher order pools. Depending on how the DSH cuts are implemented, NYCHH could see an immediate cut of $400 million to $700 million in the first year, with the NYCHH residual pool being drained entirely within a few years. Only after the NYCHH pool is completely drained would the other pools be affected.

[5] It should also be noted, in light of current federal efforts to change "public charge" definitions in a manner that would include Medicaid use as a negative factor in determining whether to approve immigrant applications for a change or upgrade in their current immigration status. If implemented this change in immigration law will result in a large spike in uninsured patient care costs for NYCHH and other safety net hospitals as large numbers of currently insured immigrants withdraw from or avoid Medicaid enrollment to maintain their permanent resident status or seek citizenship. This will hit the NYCHH system particularly hard.

Step 1	**Public Indigent Care Pool – $139 million**	**Indigent Care Adjustment Pool – Public Hospitals $412 million**
Step 2	**Non-Health + Hospitals Public Pool (to DSH Cap): +/-$1.2 billion**	**Health + Hospitals Pool (to max. hospital DSH Caps): All residual DSH funds not distributed in Step 1, with local share paid by IGT)**
Step 3	**Voluntary and Non-Major Public ICP Pool – Up to $656 million ICP and $339 million UPL = $995 million total or such residual funds as remain after Steps 1 and 2)**	
Total		**No Change From Current Total Funds: About $3.53 billion**

The recommended reordering of the priority of DSH pools would not change the current total available funding of $3.53 billion (including current federal DSH allocation, ICP funds or IGT amounts).

The current structure and procedures for distributing funds in each pool would also remain largely unchanged, but any future reductions to DSH funding would be distributed more broadly and equally among the much wider group of voluntary and non-major public hospitals.

To ensure that no DSH money is "left on the table" the current legislative structure should be amended to reorder the pool priorities as indicated above.

In addition, to ensure that no federal DSH money is lost, current law should be amended to allow DSH and ICP funds that are not expended in any pool (due to DSH caps or other factors) to be rolled into the next pool.

Finally, in implementing the above change in pool priority, any regulatory or statutory changes should also consider the effect of implementing the 10% bonus reimbursement for ESN hospitals as discussed in point 1 above.

If the 10% bonus is implemented through use of DSH (and ICP and IGT transfers), then the DSH pool funds allocated to the pools would be reduced by roughly $750 million. This would not mean a full $750 million reduction in the total pool funds because the application of the 10% bonus would merely move the public hospitals to their DSH cap sooner, leaving them with less money to claim from the various public DSH pools.

Any unused monies in those pools (after the public hospitals have reached their DSH caps) would then flow down into the lower pools. With respect to the voluntary ESN hospitals, the 10% bonus would

mean they will end up drawing more than they currently do, so there will be some reductions in the amounts that end up in the lower pools.[6]

4. Create Tiers of Hospitals within the ICP Voluntary and Non-Major Public Pool

As noted in point 1 above, the purpose of the federal DSH program is to provide additional support and financial assistance to those hospitals that provide a "disproportionate" share of caring for Medicaid and uninsured patients. The program is not intended to serve as a broadly and evenly applied reimbursement of unpaid patient care costs distributed to all hospitals on an equal procedure-for-procedure or service-for-service basis. The built in programmatic assumption is that DSH funding is targeted to those hospitals that provide the most uncompensated care as a share of their total patient care. It thus follows that DSH funding should prioritize and be concentrated on those "disproportionate share" hospitals.

The current structure of DSH/ICP funding and distribution does provide somewhat higher funding to hospitals with higher Medicaid and uninsured patient levels, but it still give too high a share to hospitals that don't meet these criteria.

In order to more fairly (and consistently with federal law) distribute DSH and ICP funds, and reduce the inappropriate allocation of money to hospitals that neither needs nor deserve this scarce funding, we recommend that the Voluntary and Non-Major Public ICP pool be modified to distribute money on the basis of specific tiers, with each tier receiving a set percentage of the total pool.

In order to carry out this objective and properly target the funding in this pool, which we assume to be the $995 million that is currently allocated in this year, we would propose creating the following Tiered Allocation system:

	Voluntary and Non-Major Public ICP Pool: $995 million
	Definitions
Tier 1	ESN – Enhanced Safety Net Hospitals as defined in PHL Section 2807-c(34)
Tier 2	Non-ESN Safety Net Hospitals – Uncompensated Medicaid/Uninsured Care Costs as a percentage of Total Costs (Based on DSH Audit Report) above a determined percentage rate.
Tier 3	Remaining Voluntary Hospitals (unless in Tier 4 Excluded Category) – Uncompensated Medicaid/Uninsured Care Costs not meeting the threshold for inclusion in Tier 2.
Tier 4	Excluded Low Medicaid/Uninsured: Any non-ESN Hospital with Uncompensated/Uninsured Care Costs as a percentage of total costs that places them in the bottom 10% of all hospitals.

[6] If we adopt the 10% bonus reimbursement and reordering of the pools as proposed in points 1 and 2 above, the Voluntary and Non-Major Public ICP pool would no longer be guaranteed to receive $995 million. It would in effect become the new "residual pool." In the current year, however, there would be no reduction in the total pool money, since the public hospitals are all expected to receive their full DSH allotment in the current year and any increases in the voluntary ESN allotments would be cost neutral vis a vis the entire pool (the net funding for voluntary hospitals would be the same, $3.52 billion, but the distribution of that amount would change in favor of the ESN hospitals). In future years, however, any reductions in DSH money for New York would impact the total available in the ICP voluntary pool.

Under this proposal to "Tier" hospitals in the Voluntary and Non-Major Public ICP Pool, the following principles and standards would apply:

(a) Within each Tier, all hospitals will receive DSH funding to their hospital-specific DSH cap;

(b) Funds will be distributed based on formulas, as modified in Proposal/Recommendation #4 below, but with the allocation of funds based on the final "Nominal Need" of each hospital divided by the funds available within its particular Tier, rather than the total pool;

(c) All funds within the pool that are unallocated due to operation of the DSH caps for specific hospitals will be reallocated to the remaining hospitals within that Tier, using the same distribution formulas used in the first allocation;

(d) Any remaining unallocated funds in each Tier will flow to the next Tier to be distributed to hospitals within that Tier; and

(e) Each Tier within the pool will receive a set percentage of the available Tier funds. The allocation of funds to each Tier should be determined to provide higher payments to the higher Medicaid/uninsured use hospitals.[7]

5. Change the Formulas for Distribution of ICP Funds In the Voluntary and Non-Major Public Pool to Target Hospitals With the Highest Rates of Medicaid and Uninsured Patients

As noted in NYSNA's October 9, 2018 submission to the Workgroup, the formulas used to determine need and distribute ICP funding are biased in several ways. The use of state-wide average cost adjustments (SWAF) are biased against those hospitals with higher than average costs to the benefit of those with lower costs. In addition, the formulas for calculating the allocations inappropriately distributes money in a manner that benefits lower Medicaid/Uninsured patient care hospitals at the expense of higher Medicaid/Uninsured patient care hospitals. These distortions in the distributions of funding include the following distorting factors in the formulas for calculating nominal need: the use of a 40% floor for all hospitals, failure to include outpatient services as a factor, failure to include uninsured patient care costs, and failure to consider hospital profitability (which is directly linked to such structural factors as patient payer mix and avoidance of low reimbursement services such as psychiatric or emergency services).

[7] For example, Tier 1 could receive 30% of the total pool funds, Tier 2 30% of the total pool funds, Tier 3 40% of the total funds, and Tier 4 0% of the total funds available for the pool. Note that these percentages are for illustrative purposes only. A full costing would have to be carried out to determine and establish in statute an appropriate percentage allocation for each Tier within the Voluntary and Non-Major Public Pool with the goal of allocating funding within the pool to each Tier so that hospitals with the highest Medicaid and Uninsured patient levels receive a greater share of pool funds.

The distribution of ICP funds should accordingly be corrected to remove these imbalances with the following changes in the distribution formulas:

a) Use Actual Cost Adjustment Instead of Statewide SWAF Average Cost Adjustment In Determining Base Uncompensated Care for the Uninsured

The current formula for determining ICP distributions starts with the in-patient and out-patient uninsured units of service and multiplies them by the Medicaid rate of reimbursement for each such service to arrive at a base uncompensated care figure.

The in-patient uncompensated care cost for the uninsured is then multiplied by an average Statewide Cost Adjustment Factor (SWAF) of 1.3.

The out-patient uncompensated care cost is multiplied by an average Statewide Cost Adjustment Factor (SWAF) of 1.9.

The formula then produces a "Net Adjusted Uncompensated Care Need" for each hospital. This number is then adjusted again to arrive at the final "Nominal Need" factor that is used to determine each hospital's share of the total ICP pool.

The use of a statewide average SWAF for both in-patient and out-patient costs penalizes hospitals in areas with costs that are above the state average and benefits hospitals in areas with costs below the state average.

Recommendation: Replace the state-wide average SWAF for both in-patient and out-patient cost adjustments with an adjustment factor based on actual cost variations in specific geographic areas or health care markets to create a "Net Adjusted Uncompensated Care Need" that closely tracks actual cost variations in each local market area.

b) Incorporate Medicaid Inpatient and Outpatient Utilization Rates in the Formula for Arriving at "Nominal Need"

The current formula for determining the allocation of ICP funds starts with a calculation of "Net Adjusted Uncompensated Care Need" that includes uncompensated Medicaid/uninsured costs for both in-patient and out-patient services.

In determining the "Nominal Need" number that actually determines the allocation of ICP monies, however, the actual uncompensated care costs for each hospital are then adjusted solely on the basis of the percentage of in-patient Medicaid discharges. The final determination of "Nominal Need" (which sets the final allocation of ICP funds) does not consider uncompensated out-patient costs.

This has the effect of skewing the final allocation of ICP funds against hospitals that have large out-patient footprints or that focus more on providing out-patient services to low income populations as opposed to providing specialty out-patient ambulatory services to insured patients.

Recommendation: The determination of "Nominal Need" should factor in out-patient Medicaid patient rates. For example, the "Nominal Need" could be determined by multiplying the "Net Adjust Uncompensated Care Need" by the Medicaid In-Patient utilization rate plus the Medicaid Out-Patient Utilization Rate. In the alternative, the formula could discard in-patient and out-patient utilization rates

and instead use a multiplier derived from the percentage rate of total uncompensated Medicaid/uninsured in-patient and out-patient costs compared to total costs on the DSH audit.

c) Incorporate Uninsured In-Patient and Out-Patient Rates in the Calculation of Nominal Need

As noted in point (b) above, the determination of "Nominal Need" relies exclusively on the Medicaid In-Patient Utilization rate of each hospital. This not only disadvantages hospitals with relatively higher out-patient footprints, it also penalizes hospitals with higher levels of both in-patient and out-patient uninsured losses.

Two hospitals could have the same in-patient Medicaid utilization rates, but one could have a much higher percentage of uninsured patients in both the in-patient and the out-patient settings.

This also skews the distribution of funds to the disadvantage of hospitals with relatively higher ratios of uninsured patients.

Recommendation: The determination of "Nominal Need" should factor in in-patient and out-patient uninsured usage rates. For example, the "Nominal Need" could be determined by multiplying the "Net Adjust Uncompensated Care Need" by the Medicaid IP and OP utilization rates and the Uninsured IP and OP utilization rates. In the alternative, the formula could discard in-patient and out-patient utilization rates and instead use a multiplier derived from the percentage of total uncompensated Medicaid/uninsured in-patient and out-patient costs as compared to total costs on the DSH audit.[8]

d) Remove the 40% Floor In Determining the Nominal Need Factor

The current formula for setting the final "Nominal Need" for each hospital multiplies the Medicaid Inpatient Utilization Rate (MUIR) for each hospital by a fixed and pre-determined 60% and then adds 40% to that number to arrive at the final allocation percentage. That final percentage is then applied to the "Net Adjusted Uncompensated Care Need" to arrive at the "Nominal Need" that will determine the hospital's share of the total pool funding.

This formula introduces a minimum floor of 40% for all hospitals that benefits lower Medicaid/uninsured use hospitals at the expense of higher use hospitals. This floor artificially increases the share of ICP funds distributed to lower use facilities.

For example, a hospital with a 60% MIUR would have its final "nominal need" determined by using a 76% of need adjustment while a 40% MIUR hospitals would have its need adjusted by 64%.[9]

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[8] Note that the use of this alternative – the ratio of total uncompensated care costs as a percentage of total costs (using the DSH audit data) – would incorporate the out-patient usage discussed in point (b) and the uninsured in-patient and out-patient usage discussed in point (c).

[9] Hospital A with a 60% Medicaid in-patient utilization rate would have its nominal need adjusted as follows: (60% MIUR x 60%) + 40% base/floor = 36% +40% = 76%. Hospital B with a 40% Medicaid in-patient utilization rate would have its rate determined as follows: (40% x 60%) + 40% base/floor = 24% + 40% = 64%. Note that if these two hospitals were the entire universe of hospitals receiving ICP funds, Hospital A would get 76/140 of the total amount or 54% and hospital B would get 64/140 of that amount or 46%. If the amounts were distributed without the 40% base/floor and based only on the Medicaid percentage, Hospital A would receive 60% and Hospital B 40%.

Recommendation: Determination of "Nominal Need" should be based solely on the actual rate of Medicaid + Uninsured use, without adding any floor or other adjustments to distort the distribution of funds. This could be implemented by removing the 40% floor/base and using only the actual Medicaid inpatient rate. In the alternative, the formula could discard Medicaid in-patient utilization rate entirely and instead use a multiplier derived from the percentage of total uncompensated Medicaid/uninsured in-patient and out-patient costs as compared to total costs on the DSH audit.

e) Net "Nominal Need" Should be Adjusted to Reduce Allotments To Reflect High Net Revenues, Including Patient Care and Non-Patient Care Revenues

The purpose of DSH/ICP funding is not merely to compensate all hospitals for fulfilling their charitable health care purposes. The main policy goal is to support those hospitals that have the highest rates of Medicaid and uninsured patient care.

The tax funded DSH/ICP pool moneys should accordingly be focused on supporting safety net hospitals. There is no legal or ethical basis for providing taxpayer support to augment the profits/surpluses of already profitable hospitals, especially in a context in which available funding is not sufficient to provide adequate support to vital safety net hospitals that bear a disproportionate share (hence the name of the DSH program) of caring for people who cannot afford to pay for the costs of their care.

Our hospital system is increasingly being segmented into a two-tiered system in which some hospitals disproportionately care for poor, uninsured and underinsured populations and communities, while others increasingly focus on the pursuit of the most profitable patients and service lines.

In this context, many large academic medical centers, with increasingly concentrated ownership and market power, operate with high profits but are still able to collect a large and increasing share of DSH/ICP monies that were not intended for this purpose.

The current ICP distribution formulas thus inappropriately divert ICP funding to these hospitals at the expense of hospitals that face structural financial losses because of the payer mixes with the highest levels of Medicaid and uninsured patient populations and relatively low privately insured patient rates.

These large and profitable hospitals thus generate significant surpluses/profits because of a lower relative share of Medicaid and uninsured patients and a higher mix of privately insured patients, while simultaneously serving large absolute numbers of Medicaid and uninsured patients. Because of their high volume, they receive a large share of ICP funding allocations, even though their share of Medicaid and uninsured patients is low relative to their total revenues.[10]

[10] The same dynamic also plays out in the case of smaller community hospitals that are located in or primarily serve high income local markets.

This is illustrated in the following chart using a few major hospitals as examples:

2016 Financials	NY Presbyterian	NYU Langone	Mt. Sinai	Northwell
Revenue	$7,421,079,000	$3,582,121,000	$2,368,257,000	$9,938,268,000
Costs	$7,096,220,000	$3,303,731,000	$2,208,521,000	$9,842,401,000
Net Profit	$324,859,000	$278,390,000	$159,736,000	$95,867,000
Profit %	4.58%	8.43%	7.23%	0.97%
2018 ICP	$61,861,063	$50,631,962	$40,220,144	$21,653,526

In the above examples, these four large systems generated net profits of almost $860 million, but were able to draw down more than $170 million in ICP pool funding (more than 1/5th of the entire pool).

There is no discernible rationale why these and other highly profitable hospitals should be drawing such a significant portion of ICP/DSH funding.

Recommendation 1:

The formula for determining "Nominal Need" should be further modified to account for hospital profits and losses, which correlate to the structural effects of hospital payer mixes.

Accordingly, the final "Nominal Need" factor should have an additional step in which each hospital's nominal need percentage factor is adjusted by the profit or loss rate. The profit/loss rate should be based on total hospital revenue, including (a) all reimbursements and other grants or payments received for patient care and (b) all non-patient care or operating revenue, including returns from investments and private donations to operating and capital budgets.

For example, if Hospital A and Hospital B both have final nominal need factor adjustment percentages of 60%, but Hospital A has a 5% net surplus/profit and Hospital B has a 5% net loss, then the final adjustment percentage of hospital A would be reduced by 5% to 55% and that of Hospital B would be increased by 5% to 65%.

In the case of the four hospital systems cited above, each would have its final ICP allotment (if any) reduced by the amount of their respective profit/surplus rates.

Recommendation 2:

The final distribution of ICP funds, after all adjustments discussed above, should be further subject to an absolute reduction equal to the amount of any profits/surpluses in excess of a standard cap of 3%. This would deduct from ICP allotments the amounts of net profits/surpluses of each hospitals (defined as the excess of patient care and non-patient care revenues over costs) that exceed 3% of total costs.

All gross revenue in excess of the 3% cap would be deducted, dollar for dollar, against any ICP allotment that has been determined by application of the distribution formulas.

This would have the following illustrative effect on the four hospital systems used in our example:[11]

2016 Financials	NY Presbyterian	NYU Langone	Mt. Sinai	Northwell
Revenue	$7,421,079,000	$3,582,121,000	$2,368,257,000	$9,938,268,000
Costs	$7,096,220,000	$3,303,731,000	$2,208,521,000	$9,842,401,000
Net Profit	$324,859,000	$278,390,000	$159,736,000	$95,867,000
Profit %	4.58%	8.43%	7.23%	0.97%
3% Limit/Cap	$212,886,600	$99,111,930	$66,255,630	$295,272,030
Profit in Excess (>3%)	$111,972,400	$179,278,070	$93,480,370	None
2018 ICP	$61,861,063	$50,631,962	$40,220,144	$21,653,526
ICP Reduction	($61,861,063)	($50,631,962)	($40,220,144)	None
Final ICP Payment	None	None	None	$21,653,526

6. Fully and Uniformly Enforce the Hospital Financial Assistance Law

New York State requires hospitals to provide charity care to uninsured and underinsured patients under the Hospital Financial Assistance Law (HFAL - PHL §2807-k(9-a)). This takes the form of free or reduced charges for care based on sliding scales and ability to pay.

In implementing the law, however, each hospital currently creates its own policies and procedures for receiving assistance. This has resulted in a wide range of policies and practices that raise questions about overall compliance with the letter and intent of the law.

Recommendation 1:

Adopt a single uniform statewide financial assistance application and other materials to be used by all hospitals.

Recommendation 2:

The DOH should perform audits of all elements of hospital compliance and impose meaningful penalties for failure to comply.

[11] Note that these calculations are based on existing DSH/ICP distribution formulas. If the other recommendation proposed by NYSNA were to be implemented, the allotments of funds to these hospitals would be significantly smaller.

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New York City Council Committee on Hospitals

Testimony for Oversight Hearing: Charity Care Funding for New York City Hospitals

January 16, 2019

Submitted by:
Community Service Society of New York

The Community Service Society of New York (CSS) would like to thank the Chair and members of the New York City Council Committee on Hospitals for the opportunity to submit this testimony on charity care funding for New York City hospitals. CSS is a 175-year-old 501(c)(3) non-profit dedicated to fighting poverty and strengthening New York. The organization seeks to address economic disparity through research, advocacy, and innovative programs that strengthen and benefit all New Yorkers. CSS recognizes that access to quality affordable health care is essential to building strong, equitable, and economically secure communities. For more information on CSS, visit us on the web at www.cssny.org.

The time to reform charity care is now

Federal Disproportionate Share Hospital (DSH) funding plays a critical role in supporting hospitals that provide uncompensated care to low-income patients, including NYC Health + Hospitals (H + H). New York's uninsured rate has been cut in half since the Affordable Care Act's (ACA) coverage expansions took place, but 1.1 million New Yorkers still remain uninsured. Uninsured low-income New Yorkers rely on hospital financial assistance (also known as "charity care") to receive needed medical treatment while averting financial disaster for themselves and their families.

New York City Council members have an opportunity now to weigh in on potential changes to this funding on both the federal and state levels. Our testimony will address three critical issues:

1. Distribution of DSH funding through New York's Indigent Care Pool (ICP) causes unintended consequences, benefitting rich hospitals that provide little uncompensated care at the expense of true safety net hospitals.
2. Health + Hospitals will be the first hospitals to lose funding under impending federal DSH cuts, losing an estimated $700 million to $870 million in the first year.
3. The State's regulatory system fails to adequately enforce the Hospital Financial Assistance Law (HFAL) requirements, hurting the remaining low-income uninsured patients.

New York should fix the Indigent Care Pool

Through the Indigent Care Pool, New York distributes $1.13 billion in funding, including $995 million for voluntary (private, non-profit), and $139.4 million for public hospitals. Unlike most states, which direct DSH funding only to selected hospitals that provide the most care to Medicaid and uninsured patients, New York chooses to distribute ICP funds to virtually all hospitals—including private voluntary hospitals—in the state.

Since 2000, the pool has been criticized by patient advocates for a lack of transparency in the funding distribution formula.[1] For example, some hospitals that receive significant ICP funding persistently fail to provide discounted care to financially needy patients, according to state data.

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[1] *See e.g,.* Long Island Health Access Monitoring Project, "Hospital Community Benefits and Free Care Programs: An Initial Study of Seven Long Island Hospitals," March 2001; "Neglected and Invisible: Understanding the Unmet Healthcare Needs of People on Long Island," August 2002; "Hospital Free Care Programs: A Study of Sixteen Long Island Hospitals, Part II," April 2003; Commission on the Public's Health System, "CHCCDP: Monitoring the Use of Community Health Care Conversion Demonstration Project Funds," April 2003; Public Policy and Education Fund of New York, "Hospital Free Care: Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?" September 2003; Legal Aid Society, "State Secret: How Government Fails to ensure That Uninsured and Underinsured Patients Have Access to State Charity Funds," 2003; Public Policy and Education Fund of New York , "Hospital Financial Aid: Can New Yorkers in the Capital District Access Hospital Services Paid for by Our Tax Dollars?" November 2004; "Charity Care in Rochester," Finger Lakes Health Systems Agency, September 2005; E. Benjamin and K. Gabriesheski, "The Case for Reform: How New York State's Secret Hospital Charity Care Pool Funds Fail to Help Uninsured and Underinsured New Yorkers," NYU Journal of Legislation and Public Policy, Volume 8, Number 1, Fall 2005; C. Pryor, M. Rukavina, A. Hoffman, A. Lee, "Best Kept Secrets: Are Non-Profit Hospitals Informing Patients about Charity Care Programs?" The Access Project and Community Catalyst, May 2010; A. Sager, "Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients," Commission on the Public's Health System, August 2011; Community Service Society of New York, "Incentivizing Patient Financial Assistance: How to fix New York's Hospital Indigent Care Program," February 2012; B. Hammond, "Hooked on HCRA: New York's 20-Year Health Tax Habit," Empire Center, January 2017 at 27-28; R. Tikkanen, "Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations," New York State Health Foundation, March 2017; R.S. Tikkanen et al., "Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York City," Int J Health Serv. 2017 Jul;47(3):460-476; Citizens Budget Commission, "Medicaid Supplemental Payments, The Alphabet Soup of Programs Sustaining Ailing Hospitals Faces Risks and Needs Reform," August 31, 2017; B. Hammond, "Indigent Carelessness: How not to subsidize hospital charity care," Empire Center, September 2017 at 6; Community Service Society of New York, "Unintended Consequences: How New York State Patients and Safety-Net Hospitals are Shortchanged," January 2018.

As a result of this advocacy, NYS Department of Health (SDOH) convened a workgroup in 2012 that recommended changing the distribution formula. The pre-2012 formula based distributions on hospitals' reported bad debt and charity care spending. Bad debt is the cost of care to patients who are not given discounts, including patients sent to collections, as well as unpaid cost-sharing for insured patients (i.e. deductibles, co-pays). Under federal regulations, states are no longer allowed to use bad debt as a basis for DSH distributions. The workgroup recommended a new payment method that eliminated this reliance on bad debt.

The 2012 payment method compensates hospitals for actual services provided to uninsured and Medicaid enrollees. Hospitals were concerned about the fiscal uncertainty caused by moving to a new formula, so the state included a three-year transition "collar" to limit a hospital's exposure. The collar limited losses to 2.5% first year, growing by 2.5% each year. The collar also limited how much funding a hospital could gain under the new formula. In 2015, the state extended the three-year transition period by an additional three years, and the 2018 enacted budget extended the transition period by one more year. If extensions continue, the collar will not close until the year 2050.

In January 2018, CSS published a report examining the impact of the 2012 reform, *Unintended Consequences: How New York State Patients and Safety-Net Hospitals are Shortchanged.*[2] The report found that the transition collar results in roughly 85% of ICP funding being distributed in an accountable fashion that supports hospitals that provide services to uninsured and Medicaid patients. However, the collar maintains about 15% of funding distribution based on the old, unaccountable formula. As a result, hundreds of millions of dollars flowed away from struggling true safety-net hospitals serving large numbers of uninsured and low-income patients to hospitals with healthier bottom lines. For example, in 2015 the transition collar took $138 million from 54 losing hospitals and distributed it among 93 winning hospitals. Losing hospitals, on average, provided twice as much financial assistance to low-income uninsured patients as winning hospitals. In *Unintended Consequences*, CSS recommended that New York allow the transition collar to sunset in 2018 and move to a more accountable system that ensures that ICP money directly reimburses uninsured patient care.

Nearly all policymakers agree that DSH funding should be targeted to "safety-net" hospitals. The question is, then, what is a "safety-net" hospital? National experts, such as the Institute of Medicine and the Agency for Healthcare Research and Quality (AHRQ) have resolved this question by defining a "safety-net" hospital as one that provides "a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[1] Using the AHRQ definition and 2015 data, CSS found that nine of the top ten safety-

[2] Community Service Society of New York, "Unintended Consequences: How New York State Patients and Safety-Net Hospitals are Shortchanged," January 2018, http://lghttp.58547.nexcesscdn.net/803F44A/images/nycss/images/uploads/pubs/hospital_report_-_final_1_22_18_web.pdf

net hospitals in New York state are NYC Health + Hospitals facilities; 22 of the top 25 safety-net hospitals in the state are located in New York City.

In 2018, the Governor and Legislature agreed in a budget side letter to form a NYS Indigent Care Workgroup to make recommendations regarding DSH and ICP funding. The Workgroup was convened with 22 members, including hospital representatives, consumer advocates, and labor representatives. Workgroup members met four times. During these meetings, SDOH presented three alternative ways to distribute ICP funding, and three Workgroup members presented their proposed alternative methods: the Hospital Association of New York State (HANYS), NYC Health + Hospitals, and the New York State Nurses Association (NYSNA).

CSS has joined eight other Workgroup members in endorsing the Health + Hospitals Community Coalition proposal. The H + H Community Coalition proposal eliminates the transition collar from the ICP distribution methodology. It reduces the ICP by $300 million across all hospitals proportionally and invests that $300 million in ICP funds into Medicaid increases for Safety Net and At Risk/Other Needy hospitals. The proposal addresses the disparity between well-resourced and needier hospitals, establishing a tiered Medicaid payment for safety net hospitals. Finally, public hospitals would be able to access the remaining $150 million federal in DSH funds formerly used for ICP.

The City Council should consider joining the H + H Community Coalition in urging a fairer allocation of ICP funds and an end to the transition collar.

<u>NYC should join hospitals and consumers in opposing looming DSH cuts</u>

On the federal level, the ACA mandated billions of dollars in cuts to DSH funding payments nationally because so many of the uninsured would be newly eligible for ACA insurance. These cuts were slated to take effect in 2014 but have been delayed until 2019. New York is the biggest recipient of DSH funding (16% of the national total). As a result, our state is particularly vulnerable to the planned cuts in DSH under the ACA.

While New York's robust implementation of the ACA has cut uninsured rates in half, a large number of ACA-ineligible individuals (i.e. immigrants and people who cannot afford coverage) remain uninsured. Safety net hospitals also continue to need DSH funding to supplement low Medicaid reimbursement rates.

New York distributes about $3.6 billion in state, local, and federal DSH funding to hospitals annually in four stages. New York's gross DSH cut could be $1.3 billion in FFY 2020 and $2.6 billion in FFY 2021. H + H is the largest recipient of DSH funds in New York and has on average received about $1.4 billion in DSH funding. Because the bulk of funding for Health + Hospitals comes in the fourth stage under current state law, H + H will bear the initial brunt of any federal cuts – at least the first $700 million and up to $870 million in the first year.

Cuts of this size would have a huge impact on patients and on efforts to address health disparities. Health + Hospitals still serves around 382,000 uninsured individuals annually and Health + Hospitals system is the largest provider of care to uninsured patients and patients covered by the Medicaid program in the city. While uninsurance rates in New York state have been cut in half under the Affordable Care Act (ACA), NYC Health + Hospitals facilities continue to serve a disproportionate share of the city's remaining uninsured.[2] Because members of racial and ethnic minority communities continue to have higher rates of uninsurance and are more likely to be insured by public programs such as Medicaid, hospitals that serve uninsured and publicly-insured patients have a strong role to play in reducing racial and ethnic health disparities.[3]

The New York State Department of Health, hospital representatives, and consumer advocates are united in opposing the federal funding cuts. New York City Council Members should educate New York's Congressional delegation about the need to prevent these cuts and state legislators about reforming the sequencing of state DSH distributions.

Hospitals are failing to provide discounts to eligible patients

Although the state's Hospital Financial Assistance Law (HFAL) requires hospitals that receive ICP funding to offer discounted care to uninsured low-income patients, many hospitals have long failed to meet the state's requirements for their hospital financial assistance programs. The 2012 ICP reforms included the creation of a new HFAL audit system and incentive pool to reward hospitals that follow the law and DOH guidance.

In the *Unintended Consequences* report, CSS found that SDOH's implementation of the HFAL audit failed to hold hospitals accountable. The report recommended that SDOH adopt a single uniform statewide financial assistance application and other materials to be used by all hospitals. The Governor's 2018 State of the State also indicated that it is time for all hospitals to use a uniform financial assistance application, and CSS continues to advocate for adoption of this reform.

Thank you for the opportunity to submit this testimony. Should you have any further questions, please do not hesitate to contact Elisabeth Benjamin at ebenamin@cssny.org.

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[1] M.E. Lewin, S. Altman, eds., America's Health Care Safety Net: Intact but Endangered, National Academies Press, 2000 at 21-22; J.P. Sutton et al., "Statistical Brief #213: Characteristics of Safety-Net Hospitals, 2014," Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, October 2016.

[2] United States Census Bureau, 2013 American Community Survey 1-Year Estimates; United States Census Bureau 2016 American Community Survey 1-Year Estimates; Barbara Caress and James Parrott, "On Restructuring the NYC Health + Hospitals Corporation," a report to the New York State Nurses Association, October 2017 at 22; 2014 certified beds data.

[3] United States Census Bureau, 2016 American Community Survey 1-Year Estimates; Kaiser Family Foundation analysis of March 2016 Current Population Survey, Annual Social and Economic Supplement.

Testimony submitted to:

The New York City Council
Hospitals Committee

Hearing on
Charity Care Funding for New York City Hospitals

January 16, 2019, 1:00 pm
Committee Room
City Hall
New York, NY 10007

Submitted by:

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Dear Chair Rivera and distinguished members of the Committee,

I am delighted to join you at this hearing and thank you for the opportunity to provide public comment. Today, I will be sharing with you research findings and recommendations regarding charity care payments made from the state Indigent Care Pool to New York City hospitals, from a report that I co-wrote in 2017 for the New York State Health Foundation.[1]

Background

The Indigent Care Pool was established in 1996 as the 'Bad Debt and Charity Care Pool', with a goal to compensate hospitals for care provided to uninsured and Medicaid patients, "according to their level of need due to providing charity care"[2]. The Pool is funded through federal Medicaid Disproportionate Share Hospital (DSH) funds state taxes collected via the Health Care Reform Assessment (HCRA). Prior to 2012, several investigations[3,4,5] had concluded that payments from this Pool were not adequately channeled to safety-net hospitals, and recommended that the state revise the payment formula.

In 2012, the state did exactly that, in part to comply with new federal requirements. The Affordable Care Act (ACA) prohibits using federal DSH dollars for hospital bad debt – that is, uncompensated care provided to insured individuals. Instead, DSH funds can only be used to pay for charity care, i.e. uninsured care. The state thus renamed the pool to the 'Indigent Care Pool' and removed bad debt from the calculation formula. However, the state decided to phase in the new methodology very gradually, in the interest of protecting individual hospitals from large revenue fluctuations.

Findings New York State Health Foundation report

In 2017, me and my colleagues at the CUNY School of Public Health published a report that investigated whether the 2012 reforms to the ICP payment methodology had resulted in a formula that more fairly compensated safety-net hospitals. For this report, I analyzed data from the New York State Health Department, examining charity care payments made to New York City acute care hospitals.

1) My report found that NYC private hospitals were more generously rewarded, despite providing less uninsured care. The 12 public hospitals in NYC, including Health + Hospitals and SUNY Downstate, provided more than half of all uninsured services in the City (58%) in 2013, but received only one-seventh (15%) of total ICP dollars paid to NYC hospitals in 2015.[6]

2) To further illustrate this disparity, I will share an example. Jamaica Hospital, a private non-profit hospital, and North Central Bronx, a public city hospital, both provided approximately 45,000

[1] Tikkanen R, Woolhandler S, Himmelstein D. Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations. March 2017. New York State Health Foundation.
[2] Simmons AG. 1997 New York Health Care Reform Act of 1996 – Summary of Major Provisions. New York City Office of Management and Budget, December 1997.
[3] Daines RF. A Report on the Hospital Indigent Care Pool As Required by Chapter 58 of the Laws of 2007. New York State Department of Health, January 2008.
[4] Medicaid Redesign Team (MRT) Health Disparities Work Group. Final Recommendations, October 2011. New York State Department of Health.
[5] Benjamin ER, Slagle A, Tracy C. Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program. The Community Service Society of New York, February 2012.
[6] ICP is paid on a 2-year lag relative to actual provision of care.

uninsured services in 2013. Despite providing similar levels of uninsured care, Jamaica received an ICP payment of $34.6 million – eight times greater than that received by North Central Bronx received ($4.1 million).

3) Further, we showed that ICP payments are not related to need, measured as uncompensated care – i.e. hospital financial losses from uninsured services. We found that the average private hospital in NYC incurred $6-8 million dollar in uninsured losses, yet received ICP payments that *exceeded* these losses – by 50-80% on average. Some hospitals, such as Lenox Hill and Brooklyn Hospital received payments that exceeded their uninsured losses by more than 10-fold. In contrast, uninsured losses for the city's public hospitals averaged at $42 million – i.e. 5-7 times greater than for the average private hospital – yet their ICP payments compensated only a fraction (18%) of these losses.

We found that there are two key provisions in the ICP distribution methodology that prevent these funds from going to true safety-net hospitals:

1) The **Transitional Payment Formula** that was introduced as part of the 2012 reforms, sets a floor and a ceiling for ICP payments, relative to previous years' allocations. In 2019, the floor is set at 17%, meaning that no hospital can lose more than 17% percent relative to the average amount they received in the previous three years. This floor increases by 2.5% each year.

2) The **statutory caps on public and private hospitals** are currently set at $139.4 million for public hospitals (state) and at $994.9 million for private hospitals. Because private hospitals provide fewer uninsured services than the publics overall, this higher cap essentially guarantees that these facilities continue to receive ICP payments that exceed their need.

Report Recommendations to Indigent Care Pool Allocation Methodology to Reward Safety-Net Hospitals More Fairly

1. Abolish or Accelerate the Transition Payment Formula that continues to link ICP payments to historical allocations[7]

Although the new methodology in place since 2012 is more equitable than previously, it is being phased in very gradually – meaning that the majority of ICP payments continue to be tied to hospital bad debt, which is now disallowed under the ACA.

2. Target ICP payments to a smaller group of hospitals with the greatest needs

The majority of hospitals in New York are eligible ICP payments,[8] however these crucial funds should be better targeted to a smaller number of true safety-net hospitals.[9]

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[7] This recommendation is in line with those included in proposals by (1) the NYC Health + Hospitals/Community Coalition, and (2) New York State Nurses Association, submitted to the state Indigent Care Work Group.

[8] Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid Disproportionate Share Hospital Payments, February 2016.

[9] For example using Enhanced Safety-net Hospital Criteria, as per NY state public health law § 2807-c subdiv. 34. NY state state already uses such criteria to target ICP payments to Diagnostic & Treatment Centers, which must demonstrate at least 5% of

3. **Increase ICP funds available for public hospitals to more closely align with actual provision**

The city's public hospitals are unfairly disadvantaged by the $139 million cap imposed on public hospitals, especially seeing as they provide the vast majority of charity care.

4. **Impose a facility-level ceiling for maximum ICP payments that cannot exceed need (uncompensated care costs)**

Some hospitals in NYC receive millions of dollars in payments without incurring any uncompensated care costs, while others receive payments that exceed their uninsured losses (need) by severalfold.

5. **Monitor nonprofit hospitals' charity care provision**

New York state law mandates that private hospitals operate as non-profits – i.e. charities. While some private hospitals in the City are true safety-net hospitals, other institutions do not provide much charity care. Yet, they continue to receive tax exemptions worth millions of dollars each year, because of their charitable status.[10]

To close, a note on urgency

The way in which New York allocates its charity care payments to hospitals is not only a matter of complying with federal regulations, but also of social justice. New York City has a highly segregated hospital system, whereby black and minority patients, as well as uninsured and Medicaid-insured individuals are disproportionately served by the city's public hospitals and safety-net institutions.[11] In the past two decades, the City has seen several safety-net hospitals shut down in low-income areas, while public hospitals are financially suffering alongside[12]. And when charity care funds fail to reach these institutions, their patient populations also suffer as a consequence. I urge the City Council to work together with the state Department of Health Indigent Care Work Group as they revise the payment methodology.

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patient were from self-pay/free care patients in order to receive ICP funds. Source: Gahan JW Jr. Medicaid reimbursement for D & TC's. A presentation at the 2011 Annual Conference of the Community Health Care Association of New York State.

[10] Source: Rosenbaum S, et al. The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. *Health Affairs*, 2015, 34(7):1225–1233. NOTE: Some states, like Illinois and Pennsylvania require nonprofit hospitals to meet minimum charity care requirements in order to keep their tax exemptions.

[11] Tikkanen RS, et al. Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York City. Int J Health Serv. 2017;47(3):460-476.

[12] The City of New York Office of the Mayor Bill de Blasio. One New York: Health Care For Our Neighborhoods - Transforming Health + Hospitals, 2016

New York City Council Committee on Hospitals

Hearing Testimony:
"Charity Care Funding for New York City Hospitals"

Elisabeth Wynn, Executive Vice President, Health Economics & Finance
GREATER NEW YORK HOSPITAL ASSOCIATION

Chairperson Rivera and other members of the Hospitals Committee, my name is Elisabeth Wynn, Executive Vice President for Health Economics & Finance at the Greater New York Hospital Association (GNYHA). GNYHA's membership includes all the hospitals in New York City, as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

I appreciate the opportunity to speak with you today about the importance of the Medicaid Disproportionate Share Hospital (DSH) program to New York City's public and voluntary safety net hospitals. The program provides $3.5 billion in subsidies annually to New York's hospitals in recognition of the uncompensated care they incur from treating the uninsured and Medicaid patients. This funding is critical to ensuring access to care for low-income, uninsured, and other vulnerable populations in New York City and throughout New York State.

I will touch on two topics today:

- Cuts at the Federal level under the Affordable Care Act (ACA) that threaten this funding, putting safety net hospitals and their patients at risk
- Proposals discussed by a State workgroup convened to review the methodology for distributing the Indigent Care Pool (ICP), a component of New York's DSH program

Overview of New York's Medicaid DSH Program

Federal law caps the amount of Federal DSH funding available to a state—this is called its DSH allotment. These amounts are based on each state's historical DSH spending, inflated each year by the Consumer Price Index (CPI-U); and each year, New York spends its entire DSH allotment. In fiscal year (FY) 2017, New York's allotment was $1.75 billion and, when matched with State/local funding (similar to regular Medicaid payments), Medicaid DSH funding in New York totaled $3.5 billion of which New York City's general public and voluntary hospitals received approximately $2 billion.

States are given flexibility to determine the allocation methodology for distributing Medicaid DSH funds to hospitals, up to the hospital-specific DSH cap. Under Federal law, the hospital-specific DSH cap is the sum of a hospital's losses from treating uninsured and Medicaid patients.

New York's DSH program is split into several different pools, with voluntary and public hospitals eligible for different allocations, as follows:

Table 1. FY 2017 New York State Medicaid DSH Program

Pool ($ in Millions)	Voluntary	Public	Total
Indigent Care Pool (ICP)*	$656	$139	$795
Indigent Care Adjustment (ICA)	$0	$412	$412
Public Hospital IGT	$0	$1,707	$1,707
State Psychiatric Hospitals	$0	$605	$605
Total	$656	$2,863	$3,519

*Excludes $339 million funded via Medicaid upper payment limit (UPL) payments.
IGT = intergovernmental transfers. Source: NYS DOH.

Voluntary hospitals are only eligible to receive funding from the ICP, while public hospitals also receive funding from the Indigent Care Adjustment (ICA) and the Public Hospital IGT pool. The funding allocations for the ICP and ICA pools are capped in statute, while the Public Hospital IGT pool grows each year by the CPI-U, mirroring growth in New York State's DSH allotment. In addition, the State-operated psychiatric hospitals receive $605 million annually (the maximum amount permitted under Federal law).

Under New York State law, all public hospitals receive a proportionate share of the ICA, while the Public Hospital IGT pool is distributed to eligible major public hospitals in the following order: first, State University of New York (SUNY) and county-owned hospitals receive funding up to their hospital-specific DSH caps (assuming that a local share is available, as discussed below), and then the residual funding is given to New York City (NYC) Health + Hospitals, up to the aggregate hospital-specific DSH cap of its constituent hospitals. On average, Medicaid DSH payments cover over 95% of the hospital uncompensated care losses for general public hospitals and 20% for voluntary hospitals.

Notably, the State/local share for the ICP is funded through a 1% assessment on hospital inpatient revenues, which is paid by all hospitals. Therefore, only the Federal share of the ICP is incremental revenue to hospitals, although not all hospitals have a net gain. Some hospitals have a net loss because they contribute more to the pool than they receive from the pool. In contrast, the local share for the ICA and Public Hospital IGT pools is generally paid by the county for county-owned hospitals, by New York City for NYC H+H, and by New York State for SUNY hospitals, including SUNY Downstate, so for most public hospitals, the entire payment from those pools is incremental hospital revenue.

Threat of Federal DSH Cuts

The most critical issue facing our member hospitals in 2019 is the threat, under current Federal law, of significant Medicaid DSH cuts. The cuts are scheduled to begin October 1 and would slash Federal Medicaid DSH payments nationally by $4 billion in FY 2020 and $8 billion in each of FYs 2021-2025—totaling $44 billion over the period 2020-2025. New York's share of these cuts is estimated at $600 million in FY 2020 and $1.2 billion in each of 2021-2025, or $6.6 billion over this period. However, New York State is expected to incur cuts greater than its proportionate share, in part due to our collective success in reducing New York's uninsured rate to 5%.

The DSH cuts were enacted in ACA under an assumption that hospital uncompensated care would decline as the uninsured rate dropped due to the Medicaid expansion and the availability of tax credits to help individuals purchase insurance through exchanges such as the New York State of Health. But the expected decline in hospital uncompensated care did not occur, in part because 14 states have not expanded their Medicaid programs, but also because in many states, including New York, reductions in uninsured losses were more than offset by increases in Medicaid losses.

Specifically, in New York, from 2013 to 2015, hospital losses from treating the uninsured declined by over $250 million, while losses from treating Medicaid beneficiaries increased by $1.2 billion, resulting in a net increase in hospital uncompensated care of over $950 million. The inadequacy of hospital

Medicaid rates, which reimburse hospitals for only 74% of their costs,[1] is a significant factor in the financially fragility of many New York hospitals. In fact, more than 25 voluntary hospitals across New York State—including seven in New York City—are on the State "watch list" and receive extraordinary financial support through the Value Based Payment – Quality Incentive Program (VBP QIP) to ensure that their communities have continued access to hospital services.

Clearly, given these facts, it would be inappropriate to reduce hospital DSH funding at this time. GNYHA's top priority in Washington, D.C. this year is to restore, or at least delay, these disastrous cuts that would severely jeopardize the ability of safety net hospitals throughout New York State and across the country to continue to provide care to low-income and other vulnerable populations. GNYHA is working closely with the New York's Congressional delegation, our hospital association partners, and our member hospitals to ensure continued DSH funding for our hospitals. We hope that you will support our advocacy efforts on this front.

It should be noted that if the Federal DSH cuts are implemented as scheduled, under current State law, NYC Health + Hospitals will incur 100% of the State's FY 2020 loss because it receives the DSH funding that is available after all the statutory pools are filled. The statute was written that way to benefit NYC Health + Hospitals when DSH funding was increasing annually and certainly no one anticipated the advent of Draconian DSH cuts. The fact that the statutory provision now works against NYC Health + Hospitals is of great concern, not only to NYC Health + Hospitals but to all hospitals because of their importance to the delivery system. Therefore, there was unanimous consensus among the ICP Workgroup members that if the cuts were enacted, the New York's DSH program would need to be restructured to protect funding for NYC Health + Hospitals and the State's other financially fragile safety net hospitals.

New York State ICP Workgroup

As part of the SFY 2018-19 State budget agreement, the New York State Department of Health convened a stakeholder workgroup to review the ICP methodology and make recommendations to the Executive. In particular, the workgroup focused on the implications for financially vulnerable hospitals and their patients if the "transition collar" were allowed to expire at the end of 2019, as stipulated under current law.

Overview of the ICP Methodology and "Transition Collar"

The ICP distribution methodology prior to 2013 measured uncompensated care based on bad debt and charity care (BDCC) and was called the "BDCC method." The ICP distribution methodology developed in 2013 by a prior ICP workgroup measures uncompensated care based on the cost of uninsured units of service net of payments collected from patients and is called the "units method." The actual calculation of ICP payments under the units method is as follows:

- Determine each hospital's net need for ICP funding:
    - Multiply the hospital's uninsured units of service by a cost proxy for each service, where the cost proxy is the hospital's average Medicaid rate for the service scaled up by a statewide adjustment factor to correct for the aggregate Medicaid underpayment,
    - Then offset that amount by the hospital's collections from uninsured patients.

[1] GNYHA analysis of New York State Institutional Cost Reports, 2017.

- Next, weight 60% of the hospital's net need by its inpatient Medicaid percentage to give priority to high-Medicaid hospitals in the ICP distribution.
- Then determine each hospital's share of the aggregate weighted net need of all hospitals in the public or voluntary group.
- Finally, multiply the hospital's share by the aggregate funding in the hospital group's pool.

When the methodology was implemented in 2013, there was recognition that the new methodology would cause a significant redistribution and that there were many safety net hospitals among the losers, which was of great concern. Therefore, a transition collar was implemented to moderate the impact. The transition policy was originally implemented for three years and ensured that no hospital would lose more than 2.5% in 2013, 5% in 2014, or 7.5% in 2015 from its average BDCC payment in 2010–2012. This "floor" on losses is paid for by capping hospital-specific gains in each year, referred to as the "ceiling." However, recognizing the unintended harm caused to certain hospitals by eliminating the transition collar with no mitigating adjustments, the New York State Legislature has extended the transition methodology through the next fiscal year. Thus, in 2019, no hospital will lose more than 17.5% of its prior BDCC funding.

In addition to phasing in the redistribution caused by changing the ICP method, the transition policy has also had the important benefit of reducing the naturally occurring redistribution of ICP payments from $100 million (or 10% of funding) a year to roughly $40 million (or 3% of funding) a year. Thus, it has significantly improved the predictability of ICP payments.

While it is easy to conjecture that a transition is no longer necessary, it is important to understand the implications of eliminating the transition for certain safety net hospitals, including many in New York City. The following table shows the net impact, gains, and losses for certain groups of hospitals that would result from simply eliminating the transition collar.

Table 2. Impact of Eliminating the Transition Collar on 2018 ICP Payments

$ in Millions Column1	Total	Gains	Losses
New York City			
Public	$10.7	$22.3	($11.6)
Voluntary	($21.2)	$49.2	($70.5)
VBP QIP	($16.1)	$5.9	($22.0)
ESN	($33.6)	$12.6	($46.2)
Rest of State			
Public	($10.7)	$2.8	($13.4)
Voluntary	$21.2	$85.2	($64.0)
CAH/SCH	($13.7)	$3.3	($17.0)

Note: All group subsets are not shown. Hospitals may be included in more than one groups.
ESN = Essential Safety Net; CAH = Critical Access Hospital; SCH = Sole Community Hospital

As the table shows, a straight elimination of the transition collar would mean that New York City's VBP QIP hospitals would incur losses of $22.0 million and its voluntary Essential Safety Net (ESN) hospitals would incur losses of $46.2 million. Five of the City's VBP QIP/ESN hospitals would lose *more than $5*

million: Brookdale University Hospital, Jamaica Hospital Medical Center, Montefiore Medical Center, St. Barnabas Hospital, and SUNY Downstate. Given their already extremely fragile financial condition, these hospitals simply cannot sustain these losses and maintain access to services for their communities. Policymakers must mitigate this impact when considering a change to the current transition policy.

Proposals Considered by the Workgroup

The ICP Workgroup convened four times and discussed the State's Medicaid DSH program, the impact of Federal Medicaid DSH cuts on New York's hospitals, and the current ICP methodology, including the impact of the transition collar. In general, the workgroup reached consensus on the following principles:

- The State should maximize Federal funding.
- All parties should vigorously urge Congress to restore the Federal Medicaid DSH cuts.
- If the Federal Medicaid DSH cuts are implemented, the State should restructure New York's DSH program to preserve funding for NYC Health + Hospitals.
- If the State changes the distribution of funding currently flowing through the ICP pools, it must protect other financially fragile and vulnerable safety net hospitals treating high proportions of low-income patients to ensure continued access to services in their communities.

Recognizing that simply eliminating the transition collar has unintended financial impacts for certain safety net/financially fragile hospitals, the workgroup considered three main proposals, with the goal of addressing the last consensus principle described above. A high-level description of each proposal follows.

Proposal #1: NYC Health + Hospitals/Community

The NYC Health + Hospitals/Community proposal would eliminate the transition collar policy and, in recognition of the significant Medicaid underpayments, would move $300 million from the ICP (through an across-the-board cut) into a Medicaid rate adjustment. The proposal would maintain the current public/voluntary funding splits, but the Medicaid rate adjustment would only be available for ESN[2] and other at-risk financially fragile hospitals (including VBP QIP hospitals, as well as other designated essential hospitals). The rate adjustment could either be made available for all services or weighted to prioritize primary or all ambulatory care services. In addition, the proposal would include a new $12.5 million allocation for Critical Access Hospitals (CAHs). Finally, any losses resulting from these combined policy changes to ESN and VBP QIP hospitals would be mitigated through other policy adjustments, such as increased VBP QIP funding.

The shift of $300 million (combined State/Federal funds) from the ICP to a Medicaid rate adjustment would increase the Federal DSH allotment currently available to public hospitals by $150 million. The proposal would give $100 million of the increase to NYC Health + Hospitals and the remaining $50 million to the other major public hospitals based on their relative share of the public ICP pool.

[2] Under New York State law, Essential Safety Net hospitals are defined as hospitals with categorical eligibility (i.e., public, sole community hospitals, and critical access hospitals), and hospitals meeting certain payer-mix criteria and providing specific essential community services. The payer-mix criteria include: minimum 40% Medicaid discharges, less than 25% commercial discharges, minimum 50% Medicaid and uninsured patients, and minimum 3% uninsured patients.

Proposal #2: Healthcare Association of New York State (HANYS)

HANYS' proposal would first classify hospitals into tiers based on their financial status and payer mix, with the lowest tier representing the strongest hospitals and the highest tiers representing the most financially distressed safety net hospitals. Then the proposal would modify the transition policy for each tier as follows:

- For hospitals in the top tiers (distressed, ESN, high Medicaid/uninsured), the floor would continue to decrease by 2.5% per year and the ceiling would end immediately.
- For hospitals in the middle tier, the floor would phase out over five years.
- For hospitals in the bottom tier that are eligible for ICP funding under the units method, the floor would phase out over three years.

For hospitals in the bottom tier that are ineligible for ICP funding under the units methodology, the floor would end immediately.

Proposal #3: New York State Nurses Association (NYSNA)

NYSNA supported the NYC Health + Hospitals/Community proposal described above, but made the following additional recommendations:

- Increase Medicaid rates for ESN hospitals by 10%
- Change the priority order of New York's Medicaid DSH program to prioritize funding for public hospitals
- Tier voluntary hospitals based on certain categories (ESN, non-ESN safety net, etc.), prioritizing any funding available for voluntary hospitals to ESN and other safety net hospitals, and targeting funding within tiers to hospitals with the highest percentages of Medicaid and uninsured patients

The ICP Workgroup had a robust discussion on each of these proposals but did not reach consensus or endorse a specific proposal to advance to the Executive.

GNYHA's Position

GNYHA is in the process of evaluating these, and other potential approaches, with our governance committees to determine our advocacy position. This exercise however, is severely complicated by the uncertainty of the Federal DSH cuts. Restoration of these cuts is our top advocacy priority in Washington, D.C., and success will require the combined effort of all impacted.

I am happy to take any questions that you may have.

Testimony of Judy Wessler
Retired Director
Commission on the Public's Health System
January 16, 2019
New York City Council Hospitals Committee

Thank you for the opportunity to testify today about my 35 year-long experience advocating for changes in the Indigent Care/Charity Care pool program in New York State. This is not a technical paper, which I could also write, but rather a sad history of efforts that i was involved in to attempt to make the history of this program a bit less sordid and redirect funding where it could be most useful in providing care for people.

When a funding program was once announced I was working at Community Action for Legal Services, now named Legal Services of New York, as the Health Advocacy Coordinator. In that role, I was responsible for working with community based organizations and acting as a liaison between those organizations and the lawyers and paralegals. We were aware of, and helped individuals and families that had access to health care services. It was thus surprising and encouraging to see an announcement that funding for hospitals to pay for the care of the uninsured was coming available. With several of the lawyers, we drafted a memorandum to the State Health Department recommending the use of the procedure and form in use for patients to apply for free or below cost care under the Hill-Burton program. Under this federal program, hospital receiving capital funding were required to set up a program in which patients could apply for free care. In addition, when a 20-year requirement was fulfilled, hospitals had an obligation to continue providing care to all patients but no longer had to provide the care for free. Working with a lawyer at MFY Legal Services, we sued Beth Israel Medical Center on behalf of two Lower East Side resident (Corum v. Beth Israel) on the basis that the hospital did not have a sliding fee scale in its clinics so care was not available there for the uninsured.

So this long history of working to ensure that the uninsured had some access to care began way back then. Unfortunately, the State Health Department chose to ignore our very practical recommendation and instead developed complicated method of reimbursing hospitals. Their methodology most often had very little to do with access to care for the uninsured. Much of the funding appeared to pay for bad debt, where full payment is not available even from insurance companies, instead of targeting payment for care of people who could not pay. Now 35 years later, even with federal legislation backing the need to use the federal portion of the dollars to pay for care of the uninsured, we are still struggling to get the state to do the

right thing. Some questionable politics keep happening so we are still fighting this one out.

As first Policy Coordinator and then Director of the Commission on the Public's Health System (CPHS) for 18 years, the issue of fair funding and providing care for the uninsured continued to be a major issue of concern. Work continued on efforts to appropriately redirect the charity care funding to those hospitals that actually provided the care. This also led to a focus on supporting the public health and hospital system, (HHC/H and H), because of the system's legal commitment to providing care for people regardless of their ability to pay. CPHS worked hard with some of the really good people that worked at HHC to develop the HHC Options program and to ensure a sliding fee scale for access to medications.

There was an effort in 2008 by the State Health Department to develop a new way of distributing money. A proposal developed by a Task Force was not endorsed by the state legislature after fierce lobbying by the private hospitals and Local 1199.

Another effort was tried in 2011-2012 when new Governor Andrew Cuomo was elected. He set up the Medicaid Redesign Team (MRT) make recommendations on ways to reduce the state's Medicaid budget by over $2 billion. Some of the work done by CPHS during this period can be found at (http://www.cphsnyc.org/cphs/What_We_Do/charitycare/). CPHS had a foundation grant to hire a professor to develop a new proposal to present to committees of the MRT. (http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/). This report was developed with a committee of labor representatives and community groups. Presentations were made to two committees of the MRT: the Disparities Committee and the Payment Reform Committee.

The governor and the Health Department chose to accept the recommendation of the provider-dominated payment reform committee. A smaller committee of this group met in secret and also punted on needed changes in the distribution methodology. The result was a transition for three years (called the Collar), which protected hospitals from losing much money -- thus again not directing the funding toward paying for the care of the uninsured and targeting high Medicaid-serving hospitals. This is actually language that can be found in the federal Affordable Care Act.

Work was performed in-between then and now, including reports providing documentation that the money was not going where it should be going, but little changed.

In the 2018 legislative session, the Assembly stimulated by Health Committee Chair Dick Gottfried convinced the state to include a side letter in the budget for a commitment that a Work Group would be set up to make recommendations for changes in the Charity Care distribution methodology. The group was set up and met four times. Two excellent proposals were submitted by the NYCH+H/community coalition and another by the New York State Nurses Association. These two proposals would finally right the long wrongs and would ensure that more dollars would flow to the state-defined Enhanced Safety Net Hospitals and other community hospitals in need. I am sure that you will hear presentations about these proposals, so I won't spend the time here giving the details.

What is important to know is that we need your help of the committee and the New York City Council to take this issue on and ensure that Indigent Care Pool funding is distributed to hospitals that are providing the care and are not rich with surpluses largely being used to buy up other hospitals. It is well beyond time to address these inequities.

Judy Wessler

LOCAL 420
DC 37, AFSCME, AFL-CIO

New York City's Public Healthcare Workers Union

Carmen Charles
President

Ursula Joseph
1st Vice President

Belinda Medina
2nd Vice President

Esther Simon
Secretary-Treasurer

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Recording Secretary

Testimony of Carmen Charles, President Local 420, DC37, AFSCME Before NYC Council Committee on Hospitals

Council Member Carlina Rivera, Chair

Good afternoon Chairperson Rivera and members of the Committee. I trust everyone enjoyed the holidays. As you know, my name is Carmen Charles and I am president of the more than 8,000 men and women who work within the H+H system.

Many of our members live in the communities wherein they serve. They treat everyone who comes through those hospital doors with the compassion, dignity and respect which is not always afforded to all.

Our members play a critical role in a system which has been structured to serve those most in need, who are also without the resources to pay. According to current estimates, there are some 600,000 New York City residents without federal coverage, as well as another half-million undocumented immigrants who live in fear of coming out of the shadows.

For these hundreds of thousands of New Yorkers, it falls upon H+H to provide the health care safety net. In fact, according to a 2017 report, H+H provided more than 50 percent of the states uncompensated healthcare yet received only 15 percent of its charity care dollars. At the same time private hospitals, which provided 42 percent of that charity care received 85 percent of those state dollars.
The disparity is as disheartening as it is indefensible.

And now, Mayor de Blasio has unveiled a new plan to provide universal health care for all New Yorkers. We admire the effort, as they say every little bit helps.
Unfortunately, we live in an era where a plan which will provide an additional $100-million to H+H hospitals, does little to reduce a projected $6 Billion shortfall.

Local 420 has consistently held the position that the funding formula is flawed and has a disproportionate bias against public hospitals, particularly Health+Hospitals. The state's refusal to revise the formula in a

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manner that brings equity to the distribution of charity care funds is putting an undue strain on the City's finances. We believe that the formula should be changed so that safety net hospitals serving the larger numbers of charity care patients be reimbursed at a rate reflective of this service.

We believe the state's DOH review committee on the issue was simply a shirking of its responsibility to act in a just and socially responsible manner in the distribution of charity care funds.

Nevertheless, if we are to continue to serve the healthcare needs of all New Yorkers, this Council, this Administration, and all elected officials are going to have to work together to bridge the chasm facing our public health system.

This inequity must end!

Carmen Charles
President
January 16, 2019.

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City Council Hospital Committee: Oversight - Charity Care Funding for New York City Hospital

January 16, 2019

Good afternoon,

My name is Anthony Feliciano; I am the Director of the Commission on the Public's Health System (CPHS). We believe in putting the public back in public health. For over 25 years, we have been addressing inequities in the care, treatment, delivery and distribution of health care services, programs, and resources. We like to thanks the City Council Hospital Committee for holding this hearing today on Hospital Uncompensated Care (also known as Indigent Care or Charity Care).

We are active in a Health+Hospitals (H+H) Coalition which represents low-income and at-risk patients across the State and unions representing healthcare workers largely employed by safety net institutions.

H+H Community Coalition Goals

- Eliminate the ICP transition collar without hurting essential hospitals providing services to needy communities;
- Enhance Medicaid rates for Safety Net and At Risk/Other Needy hospitals; and
- Optimize new federal Medicaid funds, while retaining all existing federal DSH funds to support these essential services

I am here because:

1. Some hospitals reap the benefit of getting State Charity Care Funds while continually and insufficiently provide care to immigrant and low-income people of color.
2. Access to health care has been seriously reduced and will continue to be if more hospitals continue to financially bleed, especially public hospitals. I am not sure that in yesterday's Governors State of the State Address, that the increase of funding in health care will fix that. I will admit that is partially because we have not learned of all the details.
3. The way charity care funding is determined must be changed, so that it more closely matches where uninsured and people on Medicaid are treated.

I would like to provide some context and background before stating our recommendations. Compensation of hospitals is officially called an "indigent care pool" but is usually referred to as an uncompensated care pool or Charity Care.

Since 1983, New York State has made special payments to hospitals providing uncompensated care. Uncompensated Care from Hospitals is funded through a Federal and State Share. Disproportionate Share Hospital ("DSH") Funds is the Federal financing mechanism to provide funding to hospitals that provide large volumes of care to Medicaid beneficiaries and uninsured patients. NYS is biggest recipient out of all the states (16% of all DSH funds or approximately $3.6 billion in DSH funding.). NY State Indigent Care Pool (ICP) Funds provide support to hospitals for offset their losses providing care to financially needy patients. The ICP pool is about $1.134 billion. NYS distributes $1.134B through the ICP composed of $139M in Public Hospital Indigent Care funds and $995M in Voluntary and Non-Major Public Indigent Care funds.

In 2007, "Manny's Law" sought to bring greater accountability to New York hospitals' classification of uncompensated care. It also obligated hospitals to create sliding fee schedules for patients, depending on their income and family size, and to notify patients about when they were eligible for discounted fees. Over the years, that implementation by voluntary hospitals has not always matched intent.

For years, claiming Bad Debt allowed several voluntary hospitals game the system in their reporting of actual care to the uninsured and people on Medicaid. Bad debt is a charge for care that has been written off by the hospital as uncollectable. It differs from charity care in that the charge in question was originally thought to have been collectable. In 2012, when it was determined that this needed to change with anticipated federal guidance (85% of funds), a political deal was made whereby a transition period, initially for three years, was allowed and a collar was place to limit a hospital's exposure (around 15% of the funds) to potential losses through the payment changes. The Transition Collar, which has been unfair, has been extended twice since then. 2018 Enacted State budget extended transition period by one year. Unfortunately, we see this happening again in the next enacted budget- unless we stop it. Basically, the transition collar allows for the inequity in the distribution to continue.

In 2018, The Governor and Legislature agreed in a side letter out to form a NYS Indigent Care Workgroup. The Workgroup was formed to address both problems with federal DSH cuts slated to begin October 1, 2019, and the ICP transition collar. The workgroup had some consensus on removing the transition collar, fixing the sequencing of the NYS DSH funds, and increasing

the Medicaid rate. However, no consensus on how to do it. The Workgroup was supposed to draft a report in December with recommendations. The report has not been completed. It is my understanding that nothing is going to be done to fix the inequity in ICP distribution this year. Basically, not changing the methods for distribution creates huge challenges for true safety-net hospitals to sustain or increase care for uninsured and Medicaid lower income patients.

Many uninsured New Yorkers rely on charity care provided by nonprofit hospitals, which receive substantial tax benefits in exchange for providing community benefits. But many of those voluntary hospitals that receive the largest tax benefits are not meeting the Federal Affordable Care Act standards, either by providing the minimal care to limited or small percentage of low-income people, especially communities of color. Despite the size of this tax expenditure, there is very little direction or monitoring of how nonprofit hospitals meet their implicit obligations under this system.

We do not believe that bad debt from patients that are uninsured should count toward charity care. Once a hospital seeks payment from a patient, patients' medical bills should be permanently excluded from the pool of available charity-care. Hundreds of millions and more has been spent from this pool and very little can be traced to care for an uninsured or Medicaid patient.

We need to be aware of the following critical issues regarding both Federal DSH and ICP Funds.

- Powerful political and monetary influences have been used to tilt charity care policy towards the protection of academic medical centers and profitable hospitals, often to the detriment of community hospitals and the communities that they serve. Several private hospital networks operate with huge surpluses and serve very low percentage of uninsured and people on Medicaid (noting it's sad that health care is about profits). The large private hospitals have grown into multi-site healthcare networks and have positioned themselves to benefit from changes in the healthcare sector. The combined net revenues of the five major private hospital networks were $877 million in 2016, up by over one-third from $650 million for all five in 2014 and 2015.[1]
- We now have a legal definition, in the state hospital code, that defines public hospitals, urban and rural voluntary hospitals that provide critical services. Although this separate from the ICP Funding Pool, it provides the guidance for the ICP method to change.
- H+H remains exposed to the brunt of looming federal DSH cuts.

- Allocation of DSH Funding is unfair. The sequencing of NYS DSH funds allocations means the hospitals which provide the most care to Medicaid and uninsured people get paid last, not first
- The Affordable Care Act (ACA) reduced DSH payments nationally because uninsured would be eligible for ACA insurance. But States like NY, have large number of ACA-ineligible individuals (i.e. immigrants and people who cannot afford coverage). Hospitals also continue to need DSH because of low Medicaid reimbursement rates.

The distribution methodology is at a crucial crossroads as the need to change how determinations are made on which hospital gets how much funding. These funds, part federal and part state but all public, should more closely match where uninsured and Medicaid patients are treated. It may seem this inequity is not in the City's control. But it is in the city interest to weigh heavily on it, especially to protect H+H and other safety-net facilities that have been impacted by an unfair and unequal distribution of ICP Funds. I would want the City Council to advocate and talk to your state colleagues about making this a priority in this year's state budget process. You can support the H+H Community Proposal. The proposal offers the following solutions:

1. Adopt new formula to allocate DSH funds in NYS that benefits true safety hospitals and patients: The new method
    - Addresses the disparity between well-resourced and needier hospitals, establishing a tiered approach for eligibility.
    - Establishes precedent for tiered Medicaid payments based on safety net need status
    - Removes ICP funding linkage to historical allocations based on bad debt

2. End the transition collar and tie ICP payments to true safety hospitals and patients. The roughly $140 million transition collar uses the old formula, based on bad debt, and rewards some hospitals that fail to serve the uninsured and under-insured. Careful analysis was done minimize any harming of the safety net and other needy hospitals providing essential services to needy communities

3. Fixes the unfair sequencing of DSH distribution. Public hospitals should not be the first to receive cuts and last to get DSH funds.

4. Improve efforts for hospitals to comply with "Manny's Law" that requires that hospitals offer low-income uninsured patients financial assistance

with their hospital care. Required to use 1 uniform NYS application. We know that institutions vary both in the capacity of their professional staff to provide care in languages other than English, and in their ability to provide culturally appropriate care. However, this is about quality and a right. There are some glaring holes that expose many low-income individuals to potentially crushing medical debt.

5. Invest $300 million ICP funds into Medicaid increases for Safety Net and At Risk/Other Needy hospitals.

6. Leverages new federal Medicaid funds, while retaining all existing federal DSH funds, allowing increased DSH funding for public hospitals.

Thank you and we hope every single Councilmember, especially members of the Hospital Committee and Health Committee, will reach out to advocates to learn about everything we are doing to change this historical inequity. We surely, will reach out for your help.

Source:

1. 2010 Instructions Institutional Cost Report (NYSICR) https://health.data.ny.gov/api/assets/329F8BC6-D396-4902-A9C2-F6B27E143924?download=true

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and Needs Reform,” August 31, 2017, available at https://cbcny.org/research/medicaid-supplemental-payments.In conclusion,

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I represent: Local 420, DC37

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