



**Testimony of the
Healthcare Association of New York State**

**Before the
New York State Department of Health**

**On
Hospital Indigent Care Funding**

July 31, 2007

Richard F. Daines, M.D., Commissioner,
New York State Department of Health

Thank you, Commissioner Daines, Chairpersons Hannon and Gottfried, and members of the Indigent Care Technical Advisory Committee (TAC) for providing the Healthcare Association of New York State (HANYs) the opportunity to testify regarding the allocation of indigent care funding to hospitals in New York State. I am Raymond Sweeney, Executive Vice President of HANYs, which represents more than 550 non-profit and public hospitals, health systems, nursing homes, and home care agencies throughout New York State.

Not-for-profit and public hospitals in New York State are driven by the mission of caring for patients 24 hours a day, seven days a week, regardless of their ability to pay. This mission extends beyond just treating patients who come through their doors—hospitals and health systems are committed to improving the health of their communities through innovative outreach programs that provide access to care. Each day, hospitals treat patients who either lack insurance or can not pay for the essential health care services that they receive. In fact, the state’s hospitals provide more than \$1.6 billion annually in uncompensated services, to low-income uninsured and under-insured patients—based on the current state definition of bad debt and charity care. In addition, hospitals also absorb approximately \$2 billion in losses annually in providing care to Medicaid recipients. As you are well aware, New York hospitals’ operating margins are at or near the bottom among all states—eight years of consecutive operating losses overall. Approximately 56% of hospitals are losing money, breaking even or operating in a precarious condition with financial margins of 1% or less in 2005, the latest year for which information is available. The indigent care funding that is made available is, therefore, critical to

sustain the ability of the state's not-for-profit and public hospitals to provide continuous access to low-income, medically indigent patients.

HANYS has been at the forefront of ensuring that fear of a hospital bill should never get in the way of a New Yorker receiving essential health care services. In January 2004, HANYS issued Board-approved guidelines which stated that hospitals should provide financial aid to patients with incomes below a certain minimum level. These guidelines also clarified that hospitals should ensure that patients are aware of their financial aid policies; that these policies are clear, respectful of patients, and tailored to patients' needs; and that the policies reflect the values and mission of the institution and patient needs. HANYS' members voluntarily complied with these guidelines, long before the recent state mandate on charity care was established.

The state has approximately 2.6 million uninsured people—15% of the state's population. HANYS and its members are committed to working with the Administration and State Legislature to reduce the number of uninsured New Yorkers. Hospitals and community health centers are the primary safety net providers of health care services to this vulnerable population, with hospital emergency departments and clinics assuming a disproportionate share of the responsibility for this population's care.

The state's Hospital Indigent Care Pool (Pool) provides a much-needed \$847 million annually to help hospitals defray the cost of providing care to this medically indigent population. However, distributions from the Pool cover only about 50 cents of every

dollar recognized as the cost of this care. Moreover, hospitals are assessed one percent of inpatient revenues (approximately \$250 million annually), which is deposited into the Indigent Care Pool and simply returned to providers. If this one percent hospital inpatient assessment is considered, the net distributions from the Pool cover less than 40% of hospitals' costs of bad debt and charity care services.

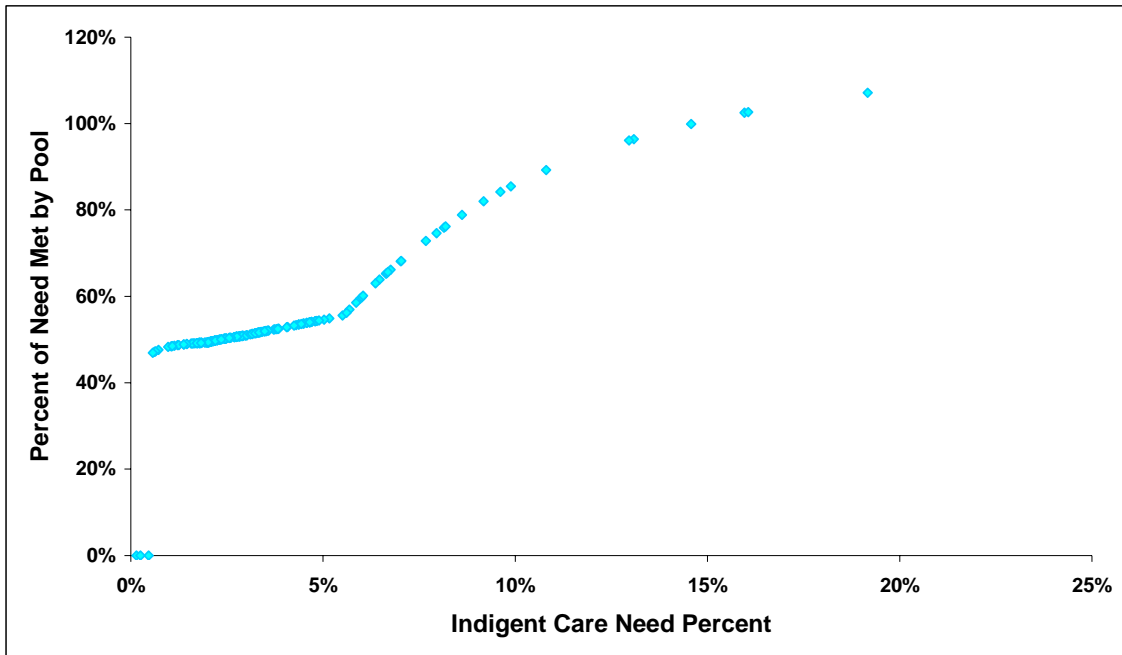
HANYS' Committee on Health Finance, with the help from a special Task Force of patient account experts, and input from the Greater New York Hospital Association and the other allied associations, have discussed the possibility of modifying and/or reforming the current indigent care need definition and Pool distribution formula. While the Finance Committee and Task Force are willing to work toward a more service statistics-based need definition, there was strong concern that a modification should only be made if and when a more valid and reliable option is available; that is: to first do no harm. The hospital community is ready to work with the Department of Health (DOH) to improve the data collection mechanism and work toward a service-based refinement. Any equitable service-based model would have to incorporate certain principles and allow adequate lead time to accurately capture and report these service-related statistics.

Refining the Current Reporting

HANYS believes that the current definition of indigent care need and its allocation formula does a reasonable job in accomplishing its purpose: to direct aid to hospitals providing uncompensated care. The statewide indigent care need is relatively stable and has been hovering around \$1.6 billion (ranging from \$1.5 billion to \$1.7 billion) for the

last ten years. The Pool has provided much-needed funds to facilities that serve a disproportionate share of indigent care. The current formula is progressive and ensures that facilities with higher proportions of indigent care receive a much higher coverage ratio than facilities with a lower indigent care burden. The following chart demonstrates coverage ratios by level of indigent care services provided.

Indigent Care Need Met by Indigent Care Pool Distribution
 Excludes: Major Public Hospitals, Rural Guaranteed, Rural Variable, Supplemental Indigent Care



Source: 2006 Indigent Care Pool Distribution, NYSDOH

We believe that hospitals generally report the data used in the methodology correctly and more consistently than in the past. The hospital chief financial officers on DOH's Technical Advisory Committee (TAC) all indicated that only indigent care costs related to patient responsibilities are included in the current indigent care need. They uniformly indicated third-party denials and unpaid disputed claims are considered third-party

“allowances” in the Institutional Cost Report (ICR) and not counted toward a hospital’s indigent care need. We believe that other hospitals treat third-party denials and disputed claims similarly. Hopefully, this clarifies one of the major misimpressions concerning the use of limited indigent care funding to cover liabilities from third-party payer denials and/or hospitals’ inefficiency in collecting from the third-party payers.

We do, however, realize that there may be some reporting inconsistencies due to the vagueness of reporting definitions in the ICR. We believe these reporting shortcomings can be fixed through a joint effort between DOH and the provider community. We are committed to help DOH to craft clearer directions and guidelines for the ICR to facilitate more consistent reporting and address some legitimate concerns raised by DOH and consumer groups. We also believe that indigent care reporting should reflect the level of financial assistance provided by hospitals in compliance with the recently enacted Hospital Patient Financial Aid Law.

Principles for Bad Debt and Charity Care

HANYS believes the following principles or design features should be considered in crafting a mechanism for providing aid for uncompensated care:

- **Continue a Proxy-Based Payment Method**

HANYS believes that distributions from the Pool should continue to be based on a proxy allocation methodology. So long as there is a reliable and valid proxy for an institution’s need, using a formula-based methodology is the most efficient

mechanism for distributing aid to hospitals for the services they provide. Alternatively, states that rely on patient service-specific billing as a basis for accessing pool funds necessitate an excessively large investment of hospital resources to administer such a system. This would divert needed funds away from patient care. In addition, as noted by Marlene Zurack, Chief Financial Officer of the New York City Health and Hospitals Corporation, requiring patient specific-documentation could have a serious negative impact on patient access. This is particularly relevant in serving undocumented immigrants who may be discouraged from seeking needed services.

- **Include the Cost of Services for Both Uninsured and Underinsured Patients**

HANYS recommends that indigent care need include uncompensated care provided to both uninsured and underinsured patients. Public policy should not differentiate between the volume of uncompensated care provided to low-income populations who are uninsured versus underinsured. Indeed, with the introduction and growth (albeit slow) of high deductible policies, an increasing portion of uncompensated care may relate to low-income underinsured patients. Hospital financial assistance policies dictate who may or may not receive financial aid from the hospital. These policies must adhere to the minimum requirements established by the recently enacted Hospital Patient Financial Aid Law. That law mandated hospitals to provide financial aid to qualifying low-income uninsured, as well as qualifying low-income insured patients who have exhausted their health care insurance benefits. It also states that hospitals, at their discretion, may extend financial assistance to insured patients for

copayments and deductibles. Many hospitals have elected to exceed this statutory floor. Hospitals that do so should continue to be supported and encouraged to offer financial assistance to as many patients as is fiscally prudent. Public policy should provide support by allowing losses incurred to be accounted for in a hospital's indigent care need for Pool distribution purposes.

- **Include Both Bad Debt and Charity Care**

Both charity care and bad debt that are the responsibility of patients should be included and given equal weight in the determination of indigent care need and in the distribution formula. The first priority of hospitals is to provide services. Most hospitals see a significant volume of patients, especially through their emergency department and ambulatory services where they may have only a limited opportunity to collect patients' financial information. Hospitals do not want to discourage the use of these needed services by requiring excessive documentation. This is particularly relevant in serving undocumented populations.

Current data indicate that for both voluntary and public hospitals, the value of bad debt reported is approximately double the value of charity care. Generally accepted accounting rules—Generally Accepted Accounting Principles (GAAP), Governmental Accounting Standards Board (GASB), and Financial Accounting Standards Board (FASB)—have stringent documentation requirements that disproportionately favor reporting unpaid balances as bad debts rather than charity

care. These accounting definitional issues can not be reconciled with in New York State alone and would require a national resolution.

The lack of financial information or patient unwillingness to complete or even apply for financial aid requires hospitals, under current accounting rules, to report unpaid services as bad debts when, in fact, many patients would have qualified for the hospital's financial assistance. Hospital representatives on the Department's TAC estimated that a truer picture would have reversed the reported data: the cost of providing free or discounted care to low-income patients far exceeds the value of services provided to patients for whom payment is expected. But the frequent inability to secure and document patient income requires that it be booked as bad debt.

To provide a more accurate picture of community benefit we would be happy to work with you on an alternative estimation technique that would better recognize the portion of unpaid balances that would most likely have qualified under the hospital's financial assistance policy, but for the lack of documentation. This could include using Census-based income information in the geographic area that the patient resides as a proxy for income to determine if the patient would have qualified for financial aid. It should be noted that this would be an estimation only—it would not satisfy current accounting requirements or comply with federal reporting expectations currently under discussion.

- **Bad Debt and Charity Care Should Be Valued at Cost**

Bad debt and charity care should be valued at the actual cost of providing care—using the Medicaid rate would grossly undervalue the amount of indigent care provided by hospitals, particularly for outpatient services which are capped at a rate well below costs.

- **Distribution Methodology Should Continue to be Progressive**

Any distribution methodology should continue to embody the principle of progressivity. Hospitals that have higher reported indigent care costs relative to their total costs should receive a larger percentage of those indigent cost covered by the Pool. As called for in the existing statute, rural hospitals and hospitals that have a substantially higher indigent care percent, currently referred to as high-need hospitals, should continue to receive special recognition through adjustments that increase their distributions from the Pool.

All or virtually all hospitals should continue to receive funding for indigent care. Some states, and the Medicare Disproportionate Share payment mechanism, are more selective in distributing aid for uncompensated care. New York’s approach is better public policy—it supports the public interest in ensuring that all hospitals provide care regardless of ability to pay. It also preserves the harmony with the new financial assistance requirements in which all hospitals must provide charity care to qualifying patients for the medically necessary health care services they require.

- **Include Indigent Care Costs for All Hospital Services**

The cost of uncompensated care for all hospital services should be included in the determination of indigent care need. Under the current methodology, charity care and bad debt for referred ambulatory services are excluded from the need calculation. Moreover, the DOH proposal from earlier this year would have limited the care to only inpatient, emergency, and general clinic care. These exclusions or limitations in coverage do not correspond with the newly enacted financial assistance law that requires hospitals to provide financial aid to patients for all medically necessary services.

Working Toward a Utilization-Based Model

While HANYS believes that the current bad debt and charity care need methodology provides a reasonable and efficient proxy for the distribution of aid, we remain willing to work with DOH to develop a need definition that would incorporate the value of bad debt and charity care provided to uninsured patients based on service data. Any methodology that would be developed must also address losses from bad debt and charity care provided to underinsured patients. Revenue received from uninsured patients should be subtracted from costs. Revenue collected from these patients should also be capped at the cost of the services they have received—any collections over costs should not offset losses.

Sufficient Lead Time to Improve Data Reporting

The hospital community through HANYS and other provider associations is committed to working with DOH to develop new data reporting instruments and better data collection tools to enable it to move toward a service-based proxy for need. Hospitals require a significant lead time, however, to re-configure their billing and reporting software to capture those data elements on the ICR that would be used as the basis for distributing Pool funds. A major change like this cannot be accomplished quickly without underlying data support.

Conclusion

HANYS recognizes that the Administration would like to change the basis for allocating indigent care aid to rely more on a service-based measure for uninsured patients. While we believe that the current methodology is reasonable and serves its intended purpose, we are more than willing to provide input to the Administration and the Legislature in the development of a more service-based methodology. The preceding comments describe the principle elements that HANYS believes should be recognized in any determination of need and distribution methodology.

HANYS also supports the efforts of the Administration and Legislature to expand access to health insurance coverage to New York's 2.6 million uninsured residents. We remain committed to achieving this important goal.

Thank you again for giving HANYS the opportunity to testify at this hearing on this very important matter.