Reforming and Restructuring the Hospital Indigent Care Pool Methodology

New York State Department of Health
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Hospital Indigent Care Pool: Findings

1. Section 2807-k of the PHL establishes the Hospital Indigent Care Pool and creates four sub-pools for allocations providing a total of $765 million/year for this Pool:
    a) Major Public Hospitals ($139.3M)
    b) Voluntary Hospital High Needs Reserve ($36M)
    c) Supplemental Indigent Care ($27M)
    d) Excess for distribution to Voluntary Hospitals ($562.7M)

2. Section 2807-w of the PHL establishes the High Need Indigent Care Pool and creates additional funding of $82 million/year for:
    a) Rural Hospitals ($17.5M)
    b) Rural Grant Awards ($9M)
    c) Additional Voluntary High Needs Reserve ($36M)
    d) Supplemental Voluntary Hospitals ($19.5M)

Hospital Indigent Care Pool: Findings

3. All together, Sections 2807-k and 2807-w provide a total of $847 million annually for Hospital Indigent Care Pool funding.

4. Hospitals are eligible for bad debt and charity care monies so long as the cost of uncompensated care exceeds a minimum of ½ of 1% of total costs.

5. Hospitals receive a greater distribution amount based on a sliding scale which provides greater levels of coverage for higher ratios of uncompensated care relative to total patient volume.

6. The Hospital Indigent Care Pool is considered a Medicaid Disproportionate Share Payment (DSH), eligible for federal matching funds.

7. Funds are currently distributed based on hospitals' reported bad debts and charity care.

Hospital Indigent Care Pool: Findings

8. Bad debts and charity care are defined using accounting principles.

9. Bad debts can include non-payments of co-pays and deductibles by patients, regardless of the patient's income or insurance status.

10. Charity care includes the portion of a patient's bill written off due to the hospital's charity care policy.

11. Bad debts and charity care definitions differ by hospital.

12. Hospitals use different accounting methodologies to determine bad debts and charity care. Two methods that can be used are the Reserve Method and the Direct Write Off Method which produce different results.

13. Accounting principles determine when bad debts are written off, affecting when these bad debts get included in the pool calculation for a given year.

Hospital Indigent Care Pool: Findings

14. Portions of a patient's bill can be deemed uncollectable as either charity care or bad debt.

15. A hospital's reported bad debt and charity care amounts cannot be tied back to a specific rendered service or establish whether the patient was uninsured or of a low income status (using existing data reported by hospitals).

16. There is little correlation between hospitals' reported BDCC need and units of service provided to self pay and free patients.

17. There are significant year-to-year swings in hospitals' reported BDCC need. These swings cannot be explained from reported data.

18. There are not significant year-to-year swings in reported units of service to self pay and free patients.

Hospital Indigent Care Pool: Findings

19. Hospitals' reported bad debt and charity care amounts are based on individual hospital's costs.

20. Referred ambulatory services are excluded from consideration in award determinations.

21. Hospital coverage ratios range from 46% to 352% of reported bad debts and charity need.

Financial Aid Law: Findings

1. In 2006 the Legislature added Section 9-a(c) to 2807-k setting forth new requirements for participation in the Indigent Care Pool for 2009.

2. The Financial Aid Law requires hospitals to offer a sliding fee scale to uninsured patients with incomes < or equal to 300% of the FPL and encourages hospitals to expand coverage to patient with higher income levels.

3. Effective January 1, 2007, the Financial Aid Law requires hospitals to maintain and report the following to DOH:
   - Hospital costs incurred and uncollected amounts in providing services to eligible patients with and eligible patients without insurance,
   - The number of patients by zip codes who applied for financial aid,
   - Reimbursement from the Indigent Care Pool,
   - Funds expended from charitable bequests for the purpose of charity care,
   - The number of Medicaid applications the hospital assisted patients in completing,
   - Hospital financial losses resulting from services provided under Medicaid,
   - The number of liens placed on primary care residences through the hospital collection process.

Financial Aid Law: Findings

4. Currently, the only connection between the two laws is that hospitals must now be in compliance with the Financial Aid Law to get Indigent Care monies.

5. Services rendered under the new Financial Aid Law mandates are not specifically captured in the existing bad debt and charity care distribution methodologies.

D&TC Indigent Care Pool: Findings

1. Section 2807-p of the PHL establishes an Indigent Care Pool for Diagnostic and Treatment Center (D&TC) providers.

2. This Pool provides a total of $48 million/year to qualifying D&TC providers and covers only services rendered to uninsured patients.

3. The D&TC Indigent Care Pool is funded by 100% HCRA funds with no federal match (not DSH eligible).

4. Unlike hospitals, the award methodology uses uninsured units of service, applicable Medicaid rates and out-of-pocket revenue from such sources as a starting point for award determinations.

5. The results are then applied to a sliding coverage scale which progressively increases subsidies as the relationship of such calculated uncompensated care costs to total operating costs increases.

6. Coverage ratios ranges from 42% to 100%. (1)

(1) Coverage ratio without hold-harmless provisions applied. With hold-harmless range is from 35% to 1,694%

Reform Objectives

1. The methodology by which hospital indigent care funds are allocated among hospitals must be transparent.

2. Supporting definitions and related reporting instructions must be specified and uniformly followed.

3. Reported data must be accurate and independently verifiable.

4. Data must include information on numbers of uninsured patients receiving care in each hospital setting (clinics, emergency rooms and inpatient services).

5. Indigent Care Pool funding should incentivize and support hospitals serving the largest numbers of low income uninsured patients.

6. Service mandates required by the new Financial Aid Law should be reflected in the distribution methodology.

Reform Objectives

7. Subsidizing uncompensated services rendered to the low income uninsured should be a priority.

8. Indigent Care Pool funding should be based on proxies which advance the efficient delivery of health care services.

9. Data collection requirements on insurance and income status of patients should minimize burden on patients and hospitals.

10. Funding objectives should be coordinated with anticipated universal coverage goals to:
    --- establish a diminishing need for uninsured subsidies to hospitals
    --- avoid incentives which would encourage marketing of inadequate insurance coverage.

11. Reform of the hospital indigent care pool allocation methodology should proceed expeditiously while minimizing huge dollar swings in one year.

Draft Reform Recommendations
Major Public Hospital Sub-Allocation

1. Maintain at existing level of $139.3 million/year.
   - Phase-out existing award levels based on a historical annual specified amount.
   - Phase-in a determination of award levels based on reported base year uninsured units of service multiplied by appropriate facility's Medicaid rate less related out-of-pocket collections.

2. Implement results of this formula to a sliding scale which progressively increases the coverage ratio for such losses as the relationship to a hospital's total patient service cost increases.

Draft Reform Recommendations
Rural Hospital Sub-Allocation

1. Continue to supplement Rural Hospital awards received through the Voluntary/Minor Public Hospital sub-allocation with a $26.5 million/year Rural Distribution Pool.

2. Eliminate awards based on fixed grants and reported bad debt and charity care write-offs.

3. Convert to an award formula similar to the one described for Major Public Hospitals weighted by bed-size for all Rural Hospitals.

4. Implement results of the above formula to a sliding scale which progressively increases the coverage ratio of losses as the relationship to a hospital's total patient services cost increases.

Draft Reform Recommendations
Voluntary/Minor Public Hospital Sub-Allocation

1. Collapse the following sub-pools into one $681.2 million pool:
   - $72 million/year Voluntary High Need Pool,
   - $27 million/year Supplemental Indigent Care Pool,
   - $19.5 million/year Supplemental Voluntary Hospital Pool, and
   - $562.7 million/year Voluntary Hospital Pool

2. Eliminate existing awards based on Graduate Medical Education HCRA Pool losses.

3. Create two sub-pools sized to reflect priority for uncompensated care of uninsured patients:
   a. $579 million/year Uninsured Pool (85% of combined Pool funds)
   b. $102.2 million/year Co-Pay & Deductible Pool (15% of combined Pool funds)

Uninsured Pool - $579M
(85% of combined Pool funds)

1. Phase-in an award formula similar to the one described for Major Public Hospitals for the majority of sub-allocation resources.

2. Implement results of the above to a sliding scale which progressively increases coverage of losses as the relationship to total reported hospital patient service cost increases.

3. Limit participation in both pools to individuals with family income below 400% of the federal poverty level or extraordinary medical needs.

Co-Pay & Deductible Pool - $102.2M
(15% of combined Pool funds)

1. Subsidize reported co-pay and deductable losses through a smaller sub-allocation based on the Direct Write-off Method.

2. Implement results of the above to a sliding scale which progressively increases coverage of losses as the relationship to total reported hospital patient service cost increases.

Indigent Care Pool
Proposed Methodology