

**A Report on the
Hospital Indigent Care Pool**
as required by
Chapter 58 of the Laws of 2007

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

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Executive Summary

Since 1983, New York State has set aside a pool of money to underwrite a portion of the uncompensated care costs incurred by hospitals. Initially termed the Hospital Bad Debt and Charity Care (BDCC) Pool and more recently the Hospital Indigent Care Pool (the Pool), this Pool currently distributes \$847 million in Medicaid funds to public and voluntary hospitals through multiple sub-Pools and multiple allocation formulas.

In an effort to assure greater transparency and accountability, in 2007, the Legislature, at the urging of the Governor, required the Commissioner of Health in conjunction with the Chairs of the Senate and Assembly Health Committees and with the assistance of a Technical Advisory Committee, to evaluate the types and amounts of services provided by hospitals and the costs incurred by hospitals in relation to the receipt of monies from the Indigent Care Pool. In addition, the 2007 legislation instructs the Commissioner to review the relationship between the Indigent Care Pool awards and the Patient Financial Aid Law (Section 2807-k(9-a)) of the Public Health Law). Enacted in 2006, the Financial Aid Law requires hospitals to offer steep discounts from typical charges to uninsured patients with incomes at or below 300 percent of the Federal Poverty Level (FPL). As required by the Legislation, this report sets out the Commissioner of Health's findings and recommendations.

A. Background on the Hospital Indigent Care Pool

The Hospital Indigent Care Pool funding is authorized in two different sections of the Public Health Law and distributed through seven sub-Pools: major public hospital pool (\$139.3 million); voluntary and minor public hospital pool (\$582.2 million); the voluntary high-need reserve pool (\$72 million); supplemental voluntary hospital pool (\$16.7 million); and the supplemental indigent care pool (\$27.0 million) and rural formulaic and grant pools (\$20.3 million and \$9 million respectively).

Funds in the seven sub-Pools are distributed using several different allocation formulas. However, with the exception of the supplemental indigent care pool and rural hospital grant sub-Pools, Pool allocation formulas start with the amounts hospitals report for "bad debt" and "charity care".

Bad debts are defined in Health Department regulations and include amounts charged to patients which remain unpaid and are determined by the hospital to be uncollectible. Charity care includes amounts hospitals determined not to bill the patient because a determination was made that the patient was medically indigent. Whether unpaid charges are treated as bad debt or charity care or a mixture thereof and when those amounts are reported to the Department of Health are a function of accounting procedures and financial policies which vary from hospital to hospital. For example, if a hospital determines, under its financial aid policies, that an uninsured patient is entitled to have its charges reduced from \$200 charge to \$50, it records a charity care loss (or charity care need) of \$150. If the patient ultimately fails to pay the \$50, that amount is then considered a bad debt. The charity care need might be reported to the Department several years before the bad debt need, depending on how quickly the hospital determines the \$50 is uncollectible.

Hospitals' reported BDCC need includes uncompensated care provided to *uninsured* patients. It also includes any co-pays or deductibles that hospitals were unable to collect from *insured* patients.

In all cases, hospitals report their bad debt and charity care need using hospital charges which the Department then "converts" to costs by applying the hospital's overall ratio of cost to charges.

In 2006, the Pool covered approximately 63% of the BDCC losses reported by hospitals, with voluntary hospital coverage ratios ranging from 46% to over 100% of reported BDCC need. The wide variation in coverage ratios are primarily a result of: (1) a nominal payment scale which provides for a greater coverage ratio as a hospital's BDCC need increases; (2) hospitals' participation in multiple pools; and, (3) the distribution of some pool dollars independent of reported BDCC need. The coverage ratio for public hospitals is approximately 23%; however, that does not include supplemental payments of \$411 million which are independent of the Indigent Care Pool.

B. Background on the Patient Financial Aid Law

The Patient Financial Aid Law was adopted in SFY 2006/07 and requires all hospitals to implement financial aid policies by January 1, 2007 that provide progressively scaled discounts to uninsured patients with incomes at or below 300% of the FPL that are benchmarked to the highest volume third-party payor for the specific applicable service. A hospital's compliance with these requirements is a condition of Pool participation on and after January 1, 2009. The Department of Health also issued guidance encouraging hospitals to extend financial aid policies to low-income insured patients who are unable to meet their copayment and deductible obligations.

C. Findings

This report reflects a review of hospital cost report data, public hearings in Syracuse and New York City, three meetings of the Technical Advisory Committee (TAC) and many discussions with hospitals, community health centers, consumers and other stakeholders. The Hospital Indigent Care Pool has evolved over 25 years. While a critical source of funding for both hospitals and patients, the Pool is now a black box with allocations based on awkward and vague definitions and multiple complicated formulas that are tied neither to care provided to uninsured patients nor the requirements of the Financial Aid Law. The report includes the following key findings of the Department of Health:

- Indigent care dollars do not follow services to individual patients and the BDCC need as currently reported by hospitals cannot be connected back to care delivered to specific patients, absolute numbers of patients, or the cost of care provided to uninsured patients.

- Indigent care funding formulas make no distinction between uncompensated care provided to *uninsured* patients and uncompensated care for *insured* patients who default on their co-pay and deductible obligations; patients' income status is likewise not a factor in Pool allocations.
- Hospitals separately report the number of units of service to uninsured patients, uninsured losses and BDCC need. However, there is no clear relationship between and among these variables.
- There is no consistent benchmark across hospitals for the cost of care provided to uninsured patients. Using each individual hospital's charges reduced to cost as the basis for most Pool allocations results in inequities in Pool allocations since they are driven by reported hospital costs that can vary significantly for comparable services.
- Existing sub-Pools are distributed using different methodologies. Distributions from the rural hospital grant pool and the supplemental indigent care pool are not related to hospital uncompensated care need. The supplemental indigent care pool targets money to teaching hospitals based on prior years shifts in professional education pool distributions and the rural hospital pool provides \$140,000 grants to rural hospitals.
- There is no connection between the Financial Aid Law requirements that hospitals offer accessible sliding fee scales to low-income uninsured patients and the distributions from the Hospital Indigent Care Pool.

D. Recommendations

The report concludes with recommendations to address the problems and concerns identified by TAC members, the public and the Department. The key recommendations are as follows:

- The existing sub-Pools should be collapsed into three: a major public hospitals pool; a voluntary and minor public hospitals pool; and a rural pool.
- The indigent care need calculation should start with inpatient and outpatient units of service to uninsured patients under the hospital financial aid policies. The reported visits and discharges should be valued at the hospital's Medicaid rates.
- Pool dollars should be targeted first to uncompensated care provided to uninsured patients (defined as patients without any insurance or without insurance for the needed care). Hospital debt related to non-payment of co-pays and deductibles by insured patients should be a second priority.
- Allocation of Pool dollars should be consistent with and support the requirements of the Patient Financial Aid Law.
- Existing "nominal" coverage scales which provide a progressively higher coverage ratio as a hospital's indigent care need to total cost ratio increases should be maintained.

- Requirements that patients document their income and insurance status should be practical and reasonable so as not to unduly burden hospitals and patients alike.
- Changes to the Indigent Care Pool allocation formulas should be phased in over a multi-year period to permit hospitals to improve data collection and reporting, and accommodate shifts in funding among hospitals.

I. Statutory Mandate

Chapter 58 of the Laws of 2007 (Chapter 58) requires the Commissioner of Health, in conjunction with the Chairs of the Senate and Assembly Health Committees, to review the current basis for determining distributions under the Hospital Indigent Care Pool (Pool) established by Sections 2807-k and 2807-w of the Public Health Law. The Indigent Care Pool currently provides \$847 million in annual subsidies to hospitals for inpatient and outpatient uncompensated care services. Chapter 58 also requires an evaluation of the relationship between Pool distributions and the recently enacted Patient Financial Aid Law that requires hospitals to provide discounts to uninsured patients with incomes at or below 300% of the Federal Poverty Level (FPL) as a condition of Pool participation on and after January 1, 2009.

Enacted as part of the 2007/08 State Budget, Chapter 58 requires the Commissioner of Health and the Chairs of the Senate and Assembly Health Committees to appoint an Indigent Care Technical Advisory Committee (TAC) to assist in the Pool evaluation. The TAC's specific duties are to assist in an evaluation of the type and amount of indigent care services provided by hospitals and the costs they incur in relation to the receipt of Pool subsidies. The TAC is also charged with evaluating the relationship between allocations from the Indigent Care Pool and the requirements of the new Patient Financial Aid Law authorized in Section 2807-k(9-a) of the Public Health Law. A listing of TAC members, meeting dates/locations, and meeting materials provided to TAC members are included as Appendices A-C.

As part of its review, the Commissioner, along with the Chairs of the Senate and Assembly Health Committees, convened public hearings in New York City and Syracuse during the summer of 2007, where consumers, community health centers, mental health agencies, physicians and hospital representatives, among others, testified. In addition, TAC members met on three occasions between June and November 2007 to review the relevant governing provisions, policies, and data underlying hospital indigent care awards. A draft of this report was also shared with TAC members and the Committee Chairs in December 2007 to solicit comments. A listing of the public hearing dates, locations, and witnesses are included as Appendix D. Copies of the testimony are available from the Department.

II. Overview of the Hospital Indigent Care Pool

A. Purpose

In 1983, New York State established a Hospital Bad Debt and Charity Care (BDCC) Pool to underwrite a portion of hospital losses associated with uncompensated care.¹ This Pool was created, in large part, to address escalating charges hospitals were imposing on third party payers to cross-subsidize losses from uncompensated care provided to uninsured patients. Over time, the Pool's initial purpose has been tempered by the inclusion of additional funding for selected groups of hospitals (e.g., rural hospitals and teaching hospitals) that are not premised on uncompensated care losses.

¹ In 1997, the Hospital Bad Debt and Charity Care Pool was renamed the Hospital Indigent Care Pool.

B. Funding Sources

Initially, the Pool was funded by payer “add-ons” to regulated inpatient hospital rates and an assessment on hospital inpatient revenues. The Department collected and distributed these Pool resources.

In 1996, the Health Care Reform Act (HCRA) replaced these inpatient payer add-ons with a more comprehensive system of payer surcharges on both inpatient and outpatient hospital services, services provided by comprehensive diagnostic and treatment centers (D&TCs), freestanding ambulatory surgery centers, and New York State licensed laboratories.² Presently, the surcharge on Medicaid payments is set at 6.54% and for all other non-Medicare payers at 8.95%. Hospitals also continue to pay a 1% annual assessment on all inpatient revenues. Subsequent HCRA legislation added other revenue sources (e.g., cigarette taxes and Empire BlueCross and BlueShield conversion stock proceeds) that further increased Pool subsidy resources. Similar to the previous rate add-ons and assessment, these proceeds are collected and pooled by the State to finance a number of important health care initiatives, including both the Hospital and D&TC Indigent Care Pools.

C. Distribution Methodologies

The Pool provides \$847 million in annual subsidies to qualifying public and voluntary hospitals to partially defray the costs of uncompensated care provided to both uninsured and insured patients primarily based on hospital reported BDCC write-offs. Award distributions qualify as Medicaid Disproportionate Share (DSH) payments making them eligible for Title XIX federal matching funds within federally imposed DSH payment limits. The Pool statutes are included as Appendix E.

The Pool has evolved into a patchwork of sub-Pools that include sub-Pools for major public hospitals;³ voluntary and minor public hospitals; high-need voluntary hospitals; rural hospitals; and targeted funding to certain hospitals that lost graduate medical education subsidies through statutory changes to the HCRA Professional Education Pool.

The allocations from the major public hospital pool are based on the percentage of total major public hospital reimbursable costs to total statewide hospital reimbursable costs. In 1997, HCRA froze the major public hospital pool allocation at the 1996 level of \$139 million. Each major public hospital’s portion of this allocation is then determined by its relative share of total reimbursable costs to total reimbursable costs for all major public hospitals as applicable in 1996.⁴

² Surcharges on NYS Licensed Laboratories were repealed as of October 1, 2000.

³ Major Public Hospitals are all State operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

⁴ In addition to the amount received from their share of the \$847 million Pool, major public hospitals also receive an indigent care annual Medicaid subsidy of \$411 million to cover the disparity which exists in uncompensated care coverage due to the use of a different award formula.

Indigent care awards to voluntary and minor public hospitals are based on the amounts each hospital writes-off for “bad debts” and “charity care.” Specific write-off decisions, in terms of amounts and timing, can and do vary among hospitals. The regulations define “bad debts” to include amounts charged to patients which remain unpaid and are determined to be uncollectible; and “charity care” to include amounts hospitals determined not to bill the patient because they have determined that the patient is medically indigent. (See Department of Health Regulations Part 86-1.11.) Unpaid amounts by any one patient can be considered either, or both, a bad debt or charity care.

The uncompensated care need determination for each hospital is initially based on the write-off of specific charges established by a hospital. The Department reduces each hospital’s reported charge-based BDCC need through a converter that adjusts these charges to costs. Consequently, each hospital’s reported BDCC need is influenced by the accounting firm it hires; the write off policies it adopts; and the unreimbursed costs it incurs in providing care to uninsured patients and insured patients. This variability has also been further exacerbated by the lack of clear and uniform definitions. For all of these reasons, as discussed further in Section V, currently there is little, if any, relationship between a hospitals’ reported BDCC need and its reported volume of services provided to uninsured patients.⁵

From 1983 until 1987, each voluntary and minor public hospital received a flat coverage rate for their reported BDCC losses, adjusted to costs, ranging from 40% to 46%. Then in 1988, the Legislature adopted a progressive coverage scale so that a hospital’s Pool allocation would increase as its reported BDCC need to total hospital cost increased. This scaled coverage is still in use today, with the added requirement that hospitals may only receive funds from the Pool if their BDCC need equals or exceeds .5% of reported hospital costs. In 1997, the Legislature also eliminated coverage for outpatient losses and established a sub-Pool for hospitals with the highest proportion of uncompensated care need. In 2000, another sub-Pool to supplement coverage for rural hospitals was also created. By 2006, the Pool covered approximately 63% of statewide BDCC losses reported by hospitals, with the highest coverage available to hospitals that participated in multiple sub-Pools.

In addition to the two major sub-Pools for major public hospitals and voluntary/minor public hospitals, there are three additional sub-Pools, each distributed pursuant to a different allocation methodology. The first is a \$72 million Voluntary Hospital High Need Reserve Pool that provides supplemental BDCC funding to hospitals whose BDCC need exceeds 4% of reported reimbursable costs. The second is a \$29 million sub-Pool for rural hospitals that distributes monies through a combination of a fixed grant of \$140,000 per hospital, supplemented by a BDCC need-based award weighted by bed size. Lastly, certain voluntary teaching hospitals participate in a \$27 million Supplemental Indigent Care sub-Pool where awards are based on each qualifying hospital’s proportionate loss of graduate medical education funding due to statutory reductions in HCRA Professional Education Pool allocations.

⁵ Hereafter, in this report, the term “uninsured” is used to refer to patients who have no health insurance coverage or lack health insurance coverage for the services they require (e.g. their health insurance does not cover dental services).

Public Health Law Section 2807-k excludes the costs of uncompensated referred ambulatory care from the BDCC need calculation for all pools. Referred ambulatory services include hospital rendered ancillary services that are ordered by medical professionals not affiliated with the hospital.

III. Overview of the Patient Financial Aid Law

The Patient Financial Aid Law was adopted in SFY 2006/07 and requires all hospitals to implement financial aid policies that conform with specified requirements by January 1, 2007. These provisions require hospitals to provide progressively scaled discounts to uninsured patients at or below 300% of the Federal Poverty Level that are benchmarked to the highest volume third-party payor for the specific applicable service. A hospital's compliance with these requirements is a condition of Pool participation on and after January 1, 2009. Guidance has been issued by the Department to assist hospitals in developing compliant procedures and to encourage them to extend financial aid beyond the minimal statutory requirements.

IV. Findings

A. Summary of Issues

Over the past 25 years, the Hospital Indigent Care Pool grew from \$162 million to the \$847 million Pool of today. The funding additions and establishment of new sub-Pools addressing discrete hospital financial needs were each important at the time of enactment. As this nine-month inquiry revealed however, the end result is an opaque Pool where hospital reported BDCC need and Pool allocations are not traceable to care rendered to uninsured patients. There is also no objective data to compare, contrast, and equitably subsidize hospitals for uninsured patients' service losses. These problems became more pronounced with the 2006 passage of the Patient Financial Aid Law requiring hospitals to provide steep discounts to uninsured patients with incomes below 300 percent of the federal poverty level and in 2007 when Governor Spitzer initiated the Partnership for Coverage, a year-long process to identify mechanisms to extend health insurance coverage to 2.6 million uninsured New Yorkers.

Common concerns about the current Pool echoed by TAC members and by witnesses at the public hearings are:

A lack of clarity on the overarching purpose of the Hospital Indigent Care Pool, the types of services, patients, and hospital losses eligible for Pool coverage and the methodologies for distributing funds to hospitals.

A lack of transparency with respect to awards from the Pool and the volume, value, site of service and patient status for which hospitals receive awards.

A lack of consistency, uniformity and accuracy of the reported data underlying awards from the Pool.

A lack of connection between the Hospital Indigent Care Pool award formulas and the mandates of the Patient Financial Aid Law (Public Health Law Section 2807-k (9-a)).

B. Lack of Clarity

There was significant discussion at the public hearings and TAC meetings as to the primary purpose of the Hospital Indigent Care Pool. All agreed that the primary purpose of the Pool is to subsidize hospital costs for rendering uncompensated care to uninsured patients. There was less consensus regarding the extent to which Pool funds should subsidize co-pay and deductibles of insured patients. Currently, the Pool definitions and distribution formulas make no distinction based on the insurance status or income levels of the patients whose unpaid bills are captured in hospital reported BDCC need. The Department recognizes that for some low-income patients' deductibles and co-pays can be quite burdensome and that for hospitals unpaid co-pays and deductibles reflect uncompensated care regardless of the patient's insurance status. Pool resources, however, are limited and should, in the Department's view, be primarily targeted for hospital care provided to uninsured patients. Using substantial Pool resources to subsidize high-deductible or otherwise inadequate insurance policies, masks and perpetuates a different problem, requiring a different solution.

As previously stated, the current definition of uncompensated care need is largely based on hospital reported bad debt and charity care accounting write-offs reduced to costs for inpatient and outpatient services. There is a substantial amount of variability on how and when hospitals determine such annual levels of bad debt write-offs. Part 86-1.11 defines bad debts as amounts considered uncollectible from payers, including self-pay, for services provided to patients. Since accounting principles determine when bad debts are written off, a facility's specific write-off method (e.g., reserve method, direct write-off method, or a combination of the two methods) affects when these bad debts are actually reflected in annual Pool calculations. Bad debts may also include unpaid co-pays and deductibles for insured patients, regardless of their income status, and other uncollected receipts from third-party billings.

Part 86-1.11 defines charity care as a reduction in charges made by the provider after a determination is made that the patient is indigent or medically indigent. In practice, however, hospital charity care policies have varied widely with certain minimums now established through recent adoption of the Patient Financial Aid Law. Thus, it will be both easier and more important going forward to tie Pool allocations directly and clearly to uncompensated care provided to patients targeted by this Patient Financial Aid Law.

The lack of clarity as to the purpose of the Pool and the definitions and calculations used to allocate limited Pool dollars, is exacerbated by multiple sub-Pools that use their own complex methodologies to allocate large shares of Pool monies to hospitals which conceal their true impact in rendering care to uninsured patients. There are also distribution methodologies in use for certain sub-Pools that are not even remotely connected to uncompensated care costs.

C. Lack of Transparency

Each hospital’s BDCC amounts are currently reported in the aggregate based on hospital charges. They cannot be tied back to a related rendered service or to a patient, much less a patient’s insurance or income status. Indeed, there appears to be little relationship between the amount a hospital reports in BDCC need in any given year and the units of service it reports to uninsured (“self-pay”) patients. This is highlighted in the testimony of Professor Jack Zwanziger, Ph.D, Director of Health Policy and Administration and The Center for Health Services Research, University of Illinois, formerly the Associate Professor of Community and Preventive Medicine at the University of Rochester.

“Despite the longstanding use and review of BDCC expense data, I found similarly high levels of unexplained and implausible year-to-year variability in both data sources.” (Table below) About half of hospitals had year-to-year fluctuations in self-pay/free service measures greater than +/- 20 percent (with the exception of ED visits), and over 40 percent of hospitals had this level of variability in BDCC measures. At the same time, few hospitals had large year-to-year variation for other key measures of hospital expenses and services (total expense, total discharges, and percent of discharges covered by Medicaid).”

The Department of Health has performed its own analysis of data reported by hospitals throughout the state with findings similar to Dr. Zwanziger’s. There is no correlation in year-to-year changes in reported BDCC to changes in self-pay and free units of service and the reported data varies significantly year to year. This is demonstrated by a random sample of hospital data in the chart below.

Comparison of Inpatient BDCC to Self-Pay and Free Discharges

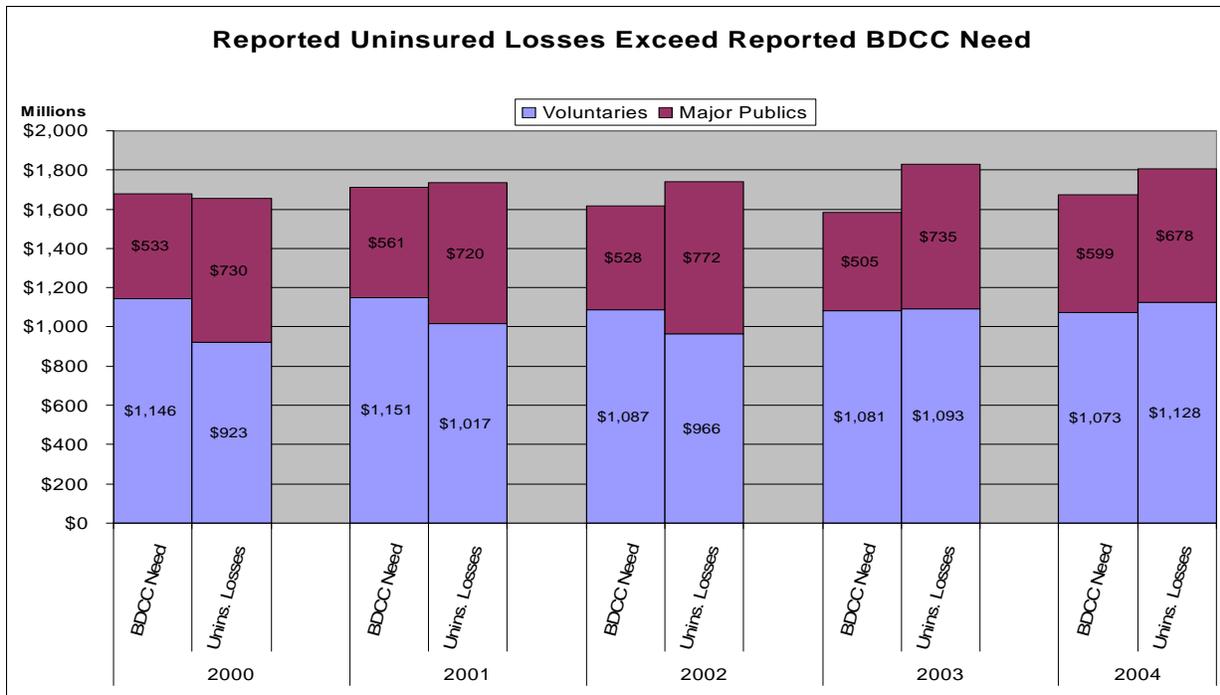
Hospital	2003 versus 2002		2004 versus 2003	
	% Change in Inpatient BDCC	% Change in Self-Pay and Free Discharges	% Change in Inpatient BDCC	% Change in Self-Pay and Free Discharges
Hospital A	7.3%	-10.0%	24.8%	52.5%
Hospital B	34.9%	29.8%	4.1%	-16.5%
Hospital C	-4.8%	-12.8%	-31.8%	-13.2%
Hospital D	-37.4%	1.7%	-23.3%	-5.2%
Hospital E	133.0%	0.2%	41.5%	-67.3%

Unlike the Hospital Indigent Care Pool, the D&TC Indigent Care Pool allocation methodology authorized under PHL §2807-p creates transparency by directly linking established subsidies to uninsured units of service reported as self-pay and free visits. Each D&TC’s uncompensated care need is determined based on reported self-pay and free visits multiplied by the facility’s specific Medicaid rate and offset by out-of-pocket payments received from such visits during the reporting period. A sliding coverage scale, similar to the one used under the hospital

methodology, progressively increases subsidies as the relationship of such calculated uncompensated care costs to total operating costs increases. The D&TC Indigent Care Pool statute is included as Appendix F.

D. Lack of Consistency, Uniformity and Accuracy

Given the definitional issues noted above, there is considerable uncertainty about the accuracy of the data being reported and used for determining existing awards. As shown in the following chart, since 2001, reported uninsured losses have exceeded BDCC losses. This is counter-intuitive because BDCC includes uncompensated care rendered to both uninsured *and* insured patients and, therefore, should be greater than uninsured losses. This strongly suggests that the reported data is not a reliable basis on which to determine Pool distributions.



- ❖ Consistent with PHL 2807-k(1)(e) for cost reporting purposes, uninsured is defined as patients without insurance or other third party coverage for the unit of service billed, including units of service, which, although provided to patients who are insured, are not covered. It shall not encompass instances of underinsurance for patients who may have some insurance
- ❖ Uninsured losses are determined as the difference between cost and revenue related to service provided to the uninsured patients for inpatient and outpatient services

The data problem emerges, at least, in part, from relying on general accounting principles and definitions. The lack of uniform definitions, clear reporting instructions, and appropriate validation procedures (e.g., independent CPA certification and State audits) have also contributed to accuracy deficiencies in the data used for determining Pool distributions.

Hospitals currently report BDCC amounts based on charges that vary significantly among hospitals and do not reflect the actual cost of rendering the service. To compensate for this variability, the existing methodology for determining uncompensated care losses “converts” hospital reported charges to costs through a methodology referred to as Ratio of Cost to Charge (RCC) that uses the ratio of a hospital’s overall costs to their charges. This approach, while necessary under the current disbursement approach, however, fails to accurately measure true uncompensated care losses and can actually produce a surplus for some hospitals thereby masking the actual financial implications from rendering uncompensated care services.

E. Lack of Relationship to Patient Financial Aid Law

The Patient Financial Aid Law enacted in 2006 (PHL §2807-k (9-a)) requires hospitals to provide discounts to uninsured patients with incomes at or below 300% of the federal poverty level (FPL) as a condition for Pool funding on and after January 1, 2009. Department guidance encourages hospitals to go further by extending greater discounts and subsidizing care for patients above 300% of the FPL. Although the Financial Aid Law requires hospitals to provide significant discounts to low-income, uninsured patients, there is currently no correlation between Pool payments and the services and discounts provided under the Financial Aid Law. The only direct connection between the two laws is a requirement that makes receipt of Pool funds conditioned on meeting the requirements of this Financial Aid Law.

The lack of connection between Pool distributions and the requirements of the Financial Aid Law is problematic in a number of respects. The Patient Financial Aid Law represents a comprehensive effort by the Legislature to ensure that uninsured patients have access to care at reasonable costs. It imposes a significant burden on hospitals and represents a critically important mandate for patients. By failing to establish a connection between Pool payments and the requirements of the Patient Financial Aid Law, the State is losing an opportunity to facilitate full compliance and to support hospitals that voluntarily implement procedures which go beyond the law’s minimal requirements.

V. Reform Recommendations

A. Addressing Clarity Concerns

The patchwork manner in which sub-Pools and supporting methodologies have evolved has obscured any reasonable understanding of the volume, level, and costs of services hospitals render to low-income, uninsured patients. Reported bad debt accounting write-offs provide no distinction between amounts attributable to insured patients who fail to pay their co-pays and deductibles and uninsured patients. Further, losses from rendering services to uninsured patients can be reported as either bad debt or charity care based on each hospital’s separately established billing policies.

This lack of clarity has been further exacerbated by the continued use of misleading data, unclear definitions, and overly complex methodologies which misdirect a large proportion of pool subsidy funding to hospitals, which according to hospital reported data, serve relatively few uninsured patients.

Consequently, the Department recommends that the existing multiple sub-Pools be collapsed into three sub-allocations:

- 1) A major public allocation remaining at its existing sub-Pool level of \$139.3 million/year with the continuation of supplemental subsidies outside the Hospital Indigent Care Pool.
- 2) A voluntary/minor public hospital allocation that would combine the existing \$562.7 million Voluntary Hospital, \$72 million Voluntary High Need Hospital, \$27 million Supplemental Indigent Care, and \$16.7 million Supplemental Voluntary hospital sub-Pools.
- 3) A rural hospital allocation that combines resources from the existing \$20.3 million Rural Distribution and \$9 million Rural Grant sub-Pools to supplement rural hospital coverage available through the above-referenced allocations.

The Department further recommends that, to the maximum extent possible, monies within each pool be distributed based on uniform and appropriately targeted methodologies as described below.

B. Creating Transparency

Transparency starts with clear definitions and uniform data which is reliable. Current shortcomings in these areas have made it impossible to quantify hospital efforts to serve uninsured patients and have contributed to inequities in award allocations. Transparency in the data and methodologies used to establish awards will advance the State's overriding objective of subsidizing reasonable costs hospitals incur in providing care to uninsured patients. This transparency can only be created by linking Pool allocations to discretely defined utilization indicators which can be collected and reported by hospitals and independently verified by the State. This approach is currently used to determine annual indigent care subsidy awards for D&TCs. Adoption of uniform data collection requirements will also permit the State to analyze where uninsured patients are getting their outpatient care (i.e., hospital clinics, emergency departments, D&TCs) and also their inpatient care. Ultimately, it will inform decisions on insurance expansions.

Consequently, the Department recommends that reported inpatient and outpatient units of service (including referred ambulatory services) for patients eligible for financial aid be used as a primary basis for establishing annual award levels (within in each sub-Pool) and that each service unit be multiplied against a fair price (rate). The current use of charges, reduced to costs, values the same service provided by different hospitals at widely varying rates. The Department recommends that each hospital's unit of service be valued by the hospital's appropriate Medicaid rate. This recommendation was the source of much discussion at the TAC meetings. The primary objection seemed to be the flawed methodology Medicaid currently uses for clinic, ambulatory surgery and emergency services. The Department intends to address those flaws starting in 2008 and believes that Medicaid is the most appropriate proxy for valuing services provided to uninsured patients. By valuing services to uninsured patients at higher amounts than services to Medicaid patients, hospitals could be encouraged to forego appropriate third-party

billing or assisting uninsured patients in obtaining Medicaid coverage. Moreover, by using reformed Medicaid rates, the Department will align incentives for hospitals serving both Medicaid and uninsured patients.

After multiplying a unit of service against the applicable Medicaid reimbursement rate, such amount should be offset by out-of-pocket amounts received from the patient. The resulting net amount would then be applied to a progressive sliding scale, as currently used, to increase subsidy coverage as a hospital's proportional relationship of calculated uncompensated care costs to total patient service costs increases.

While the Department believes that most of the indigent care pool monies should be used to underwrite the costs of care provided to uninsured patients, it recommends that some portion of each sub-Pool continue to be available to subsidize the uncompensated costs of care provided to low-income, insured patients (that is, losses due to non-payment of co-pays and deductibles) where the hospital has determined to extend its financial aid policies to such patients. This can be accomplished through the continued use of more discretely defined accounting write-offs.

C. Strengthening Linkage to the Patient Financial Aid Law:

The Patient Financial Aid Law that became effective on January 1, 2007, requires every hospital to implement discounting policies for uninsured patients that conform to the minimal requirements specified in governing statute. In its implementation of this law, the Department encouraged hospitals to consider discounting policies and procedures which would exceed minimal requirements to further improve access to care for uninsured New York State residents.

Consequently, the Department believes that the State's Pool resources should be used to support hospitals that comply with this statute and expand their policies to improve access to care for other needy uninsured patients. To create this linkage, the Department believes that the majority of Pool funds should be disbursed based on reported uninsured units of service for patients that qualify for hospital financial aid. The Patient Financial Aid Law also permits a hospital to consider financial aid for co-payments and deductibles owed by otherwise insured patients. Since it is difficult to specifically link and value these obligations to a specific rendered service, the Department would suggest that a smaller share of the Pool be separately allocated to subsidize a hospital's reported annual co-payment and deductible losses, based on a direct accounting write-off method, for patients which qualify for financial aid pursuant to a hospital's established financial aid policies.

In requiring hospitals to determine a patient's insurance and income status as a prerequisite to Pool payments, the Department is aware of the difficulties in securing this data from some patients, especially those served in the emergency department and those with unclear immigration status. Consequently, linking subsidies to each hospital's established financial aid policies allows requisite information to be secured without unduly burdening patients and staff and ensures that needed patient care is not deterred.

D. Improving Data Accuracy, Uniformity and Reproducibility:

The annual reported data required to support the Department's recommendations for a revised award distribution methodology are:

- uninsured units of service, by service category, for patients who are eligible for financial aid;
- out-of-pocket collections received from such services; and,
- reported co-payment and deductible accounting write-offs for patients eligible for financial aid under a hospital's established policies.

Ensuring accuracy in this reported data is critical for appropriately directing limited subsidy funding to hospitals serving the largest numbers of low-income, uninsured patients. Since a refinement and improvement in the data currently reported by hospitals would be required to reform \$847 million in Pool allocations, such reforms should be phased-in over a multi-year period to permit hospitals to improve the accuracy of the reported data and to respond to the shifting emphasis on care to uninsured, low-income patients. Indeed, with clarifications enunciated by the Department in 2007, the Department expects the 2007 data will be better than earlier years' data. We would also propose that this reported data be independently verified as part of the hospital's Institutional Cost Report (ICR) certification process and audited by the State to ensure compliance with applicable reporting instructions.

VI. Conclusion

The Department's recommendations address key issues raised by TAC members and public hearing witnesses regarding existing methodologies used for allocating the \$847 million Pool. Most significantly, recommended reforms will ensure that Pool funds are allocated through the use of uniform and accurate data, are subject to transparent allocation formulas, and are primarily targeted to subsidize hospitals for losses incurred in serving to low-income patients that qualify for assistance under hospital patient financial aid policies. Consequently, these reforms align and reinforce the goals of the Indigent Care Pool statute and the Patient Financial Aid Law through the use of distribution methodologies that will reward hospitals for tailoring financial aid policies that meet all legal requirements and are responsive to the needs of the communities and patient populations they serve.

A multi-year phase-in of these changes will also ensure access to the appropriate data needed to effectively implement proposed formula modifications and allow hospitals time to adjust to potential shifts in Pool subsidy allocations.

INDIGENT CARE TECHNICAL ADVISORY COMMITTEE MEMBERS

NAME	ORGANIZATION
Ms. Elisabeth Benjamin	Community Service Society of New York
Ms. Trilby deJung Staff Attorney	Empire Justice Center
Mr. Peter Epp, CPA Managing Director	RSM McGladrey Business Services, Inc.
Mr. David Hardy Chief Financial Officer	Cortland Regional Medical Center
Ms. June Hoeflich Interim Chief Executive Officer	Sheehan Memorial Hospital
Mr. John Holahan	Urban Institute
Ms. Rochelle Korman Partner	Patterson, Belknap, Webb and Tyler, LLP
Mr. Rick Langfelder Executive Vice President and Chief Financial Officer	Lutheran Medical Center
Ms. Phyllis Lantos Chief Financial Officer	New York Presbyterian Hospital
Mr. Mark Scherzer Counsel	New Yorkers for Accessible Health Coverage
Mr. Robert Shapiro Senior Vice President and Chief Financial Officer	North Shore-Long Island Jewish Health System
Mr. Len Shute	Strong Memorial Hospital
Ms. Marlene Zurack	Health and Hospital Corporation
Senator Kemp Hannon Chair	Senate Committee on Health
Mr. Richard N. Gottfried Chair	Assembly Committee on Health
Richard F. Daines, M.D. Commissioner	New York State Department of Health
Deborah Bachrach Deputy Commissioner	New York State Department of Health
John Ulberg	New York State Department of Health
John Gahan	New York State Department of Health

**Indigent Care
Technical Advisory Committee
Meeting Dates and Locations**

First TAC Meeting:

June 13, 2007
Swyer Theater in the Egg
Empire State Plaza
Albany, New York 12237

Second TAC Meeting:

September 18, 2007
Metropolitan Area Regional Office
90 Church Street
New Your, New York 10007

Third TAC Meeting:

November 14, 2007
Meeting Rooms 2-3
Empire State Plaza
Albany, New York 12237

HOSPITAL INDIGENT CARE
PUBLIC HEARINGS

Date: July 31, 2007

Location: Assembly Hearing Room
250 Broadway
New York, New York 10007

<u>Order</u>	<u>Speakers Presenting Testimony</u>	<u>Organization Represented</u>
1	Raymond Sweeney	Health Care Association of New York State
2	Pat Wang	Greater New York Hospital Association
3	Kate Breslin	Community Health Care Association of NYS
4	Judy Wessler	Commission on Public's Health System
5	Jenny Rejeske	New York Immigration Coalition
6	Annie Lai	Urban Justice Center
7	Juanita Lara	Latin American Integration Center
8	Gladys Dixon	Coler-Goldwater
9	Gloria Thomas	Kings County Hospital
10	Wilber Weder	Bellevue Hospital Community Advisory Board

Date: August 13, 2007

Location: Sheraton Syracuse University Hotel & Conference Ctr.
801 University Avenue
Syracuse, New York 13210

<u>Order</u>	<u>Speakers Presenting Testimony</u>	<u>Organization Represented</u>
1	Gary Fitzgerald	Iroquois Healthcare Alliance
2	Arthur Gianelli	Nassau Healthcare Corporation
	John O'Connell	Nassau Healthcare Corporation
	Gary Bie	Nassau Healthcare Corporation
3	Joseph McDonald	Catholic Health System
4	Norman Wetterau	New York State Academy of Family Physicians
5	Phillip Saperia	The Coalition of Behavioral Health Agencies, Inc.
6	Diane Ashley	Rochester Regional Healthcare Advocates

**Submitted Written
Testimony**

Organization Represented

1	Rosemarie Guercia, M.D. Donna Kass, PT	Long Island Health Access Monitoring Project Long Island Health Access Monitoring Project
2	Jo Wiederhorn	New York State Academic Dental Centers
3	JoAnn Casado Bob Lederer	The Bronx Health Link, Inc. The Bronx Health Link, Inc.
4	Jack Zwanzier, Ph.D.	The Center for Health Services Research



Hospital Indigent Care Pool Technical Advisory Committee Summary

NYS Department of Health

June 13, 2007



The Charge to the Indigent Care Technical Advisory Committee

- Assist the Commissioner of Health and the Chairs of the Senate and Assembly Health Committees in their evaluation of the \$847 million in hospital indigent care pool monies
- Evaluate the type and amount of services provided by hospitals and the costs incurred by hospitals in relation to receipt of monies from the indigent care pool
- Evaluate the relationship between the indigent care pool monies and the hospitals' obligation under the newly enacted hospital patient financial aid law

Evaluation Process For Technical Advisory Committee

- June 13, 2007 First meeting of TAC to review current law, rules and data
- July/August 2007 Public hearings in NYC and Syracuse
- September 2007 Meeting of TAC in NYC
- November 2007 Final meeting of TAC in Albany
- December 2007 Commissioner of Health issues report

Overview of Indigent Care Pool

- **Public Health Law (PHL) and Regulations set forth the funding and distribution methodologies for the pool**
- **\$847M annually funded through state Medicaid appropriations**
- **Payments are Medicaid Disproportionate Share Payments (DSH) and are subject to Federal Disproportionate Share payment caps**
 - ✓ DSH are Medicaid payments to hospitals to recognize the additional costs in treating larger numbers of Medicaid and low income patients
- **PHL allocates pool resources to provide specified subsidies for:**
 - ✓ Public hospitals
 - ✓ Voluntary hospitals
 - ✓ Rural hospitals (federal or state rural designation or low density population within their service area)
 - ✓ Voluntary high need hospitals
- **Distributions from these allocations are based upon several different methodologies**

Funding Sources for \$847M Indigent Care Pool

- **50% Federal Title XIX (I.e., Medicaid) matching funds for hospital DSH payments**
- **50% NYS HCRA Pool proceeds including:**
 - ✓ Patient services surcharges on specified revenue received for hospital, comprehensive diagnostic and treatment centers and freestanding ambulatory surgery rendered services
 - ✓ Covered-Lives assessment applies to insurers for each enrolled resident
 - ✓ 1% Assessment on hospital net inpatient revenues
 - ✓ Dedicated receipts from the sale of stocks to convert Empire Blue Cross and Blue Shield to a for-profit insurer
 - ✓ A portion of NYS Cigarette tax receipts

Medicaid Disproportionate Share Payments

- Medicaid Disproportionate Share (DSH) payments
 - ✓ Allows us to fund these expenditures through a 50% federal match.
 - ✓ Federal law limits each hospital's receipt of such payments to their annually established Medicaid and Self Pay losses (DSH Cap)
 - ✓ Medicaid State Plan requires that each hospital's annual DSH cap be determined by losses reported through Exhibit 47 of the ICR submitted by the hospital
- For any portion of an annual award that remains above the "final" DSH Cap, State law allows the hospital to receive the non-Federal share component (i.e., 50%) of such amount
- Only 6 hospitals had their Indigent Care distributions reduced due to the DSH cap for 2004, which resulted in a gross impact of \$13.2M

Indigent Care Pool
2007

Total Funds Available
\$847M

\$765M
PHL 2807-k

\$82M
PHL 2807-w

\$139.3M
Major Public Allocation

\$36M
Voluntary Hospital High Need Reserve

\$27M
Supplemental Indigent Care Distributions

\$562.7M
Excess for distribution to Voluntaries

\$140,000 each
Rural Grant Award

\$17.5M
Rural Indigent Distributions

\$26.5M
Rural Distribution

\$36M
Additional Voluntary High Need Reserve

\$19.5M
Supplemental Voluntary Hospital Distributions

Glossary of Key Terms for Need Based Methodologies

➤ **Uncompensated Care (PHL 2807-k)**

- ✓ The cost of Bad Debts and Charity Care (BDCC) for hospital inpatient and outpatient services, excluding referred ambulatory services (ancillary services provided by hospital as a result of an outside physician's referral)

➤ **Bad Debts (Part 86-1.11)**

- ✓ Amounts which are considered to be uncollectible from payers (including self pay) related to services provided to patients. Bad debts are determined in accordance with generally accepted accounting principles which recognize the direct charge-off method, the reserve method, or a combination of the direct charge-off method and the reserve method (bad debts include co-pay and deductibles not paid; insured services which are denied payment; or patients who do not pay their bill)

➤ **Charity Care (Part 86-1.11)**

- ✓ The reduction in charges made by the provider of services because the patient is “indigent or medically indigent.” Courtesy allowances, such as free or reduced-charges to other than the “indigent or medically indigent”, are not considered charity care (charity care includes services rendered to patients without financial means to pay for such services)

Glossary of Key Terms for Need Based Methodologies (con't)

➤ Targeted Need (PHL 2807-k)

- ✓ The relationship of Bad Debt and Charity Care need (BDCC) to hospital costs expressed as a percentage

➤ Nominal Payment Amount (NPA) (PHL 2807-k)

- ✓ The total dollars attributable to the application of an increasing coverage scale applied to the hospital's BDCC

➤ Uninsured Care (PHL 2807-k(1)(e))

- ✓ Losses from the cost of bad debts and charity care (BDCC) of a general hospital for inpatient and ambulatory services (excluding referred ambulatory services), which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient

New York State Public Health Law establishes the methodology for distributions for each sub-allocation of the Indigent Care Pool

- Funds for Voluntary Hospitals, Supplemental Voluntary, Supplemental, Rural and Voluntary High Need distributions are allocated based upon “uncompensated care need”
- Funds in the Major Public, Rural and Supplemental Indigent Care allocations are distributed based upon alternative methodologies

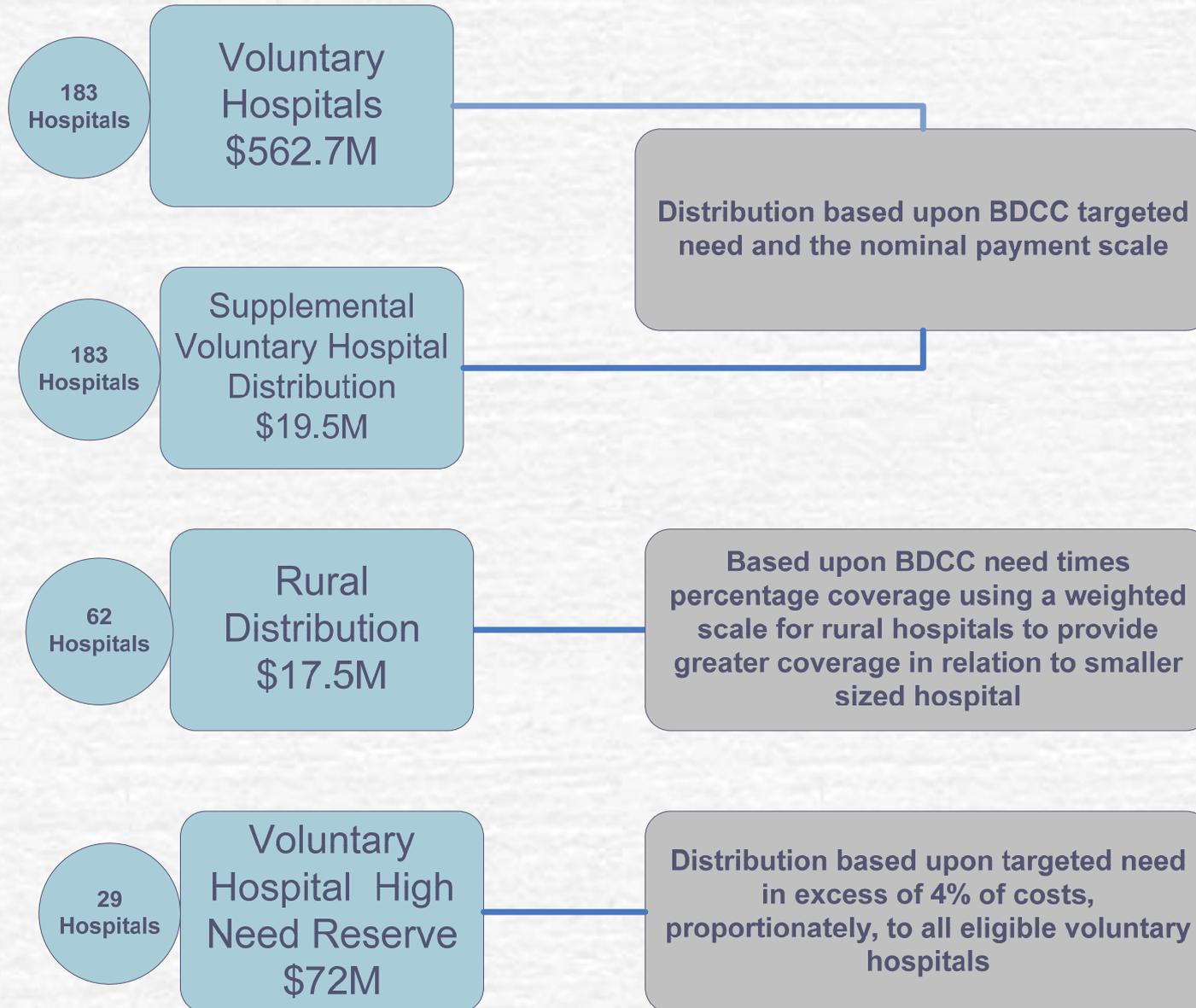
Example of Calculation of BDCC

Data Elements		
Inpatient Costs	\$ 80,000,000	
Inpatient Reported Charges	\$ 200,000,000	
Inpatient Charge Converter	40%	
Inpatient Reported Bad Debts	\$ 4,000,000	
Inpatient Reported Charity Care	\$ 4,250,000	
Inpatient Bad Debt & Charity Care at Cost (Line 4 +Line 5) X Line 3		\$ 3,300,000
Outpatient Costs	\$ 20,000,000	
Outpatient Reported Charges	\$ 40,000,000	
Outpatient Charge Converter	50%	
Outpatient Reported Bad Debts	\$ 1,400,000	
Outpatient Reported Charity Care	\$ 1,000,000	
Outpatient Bad Debt and Charity Care at Cost (Line 10 + Line 11) x Line 9		\$ 1,200,000
Hospital Inpatient and Outpatient Uncompensated Care at Cost (Line 6+Line 12)		\$ 4,500,000

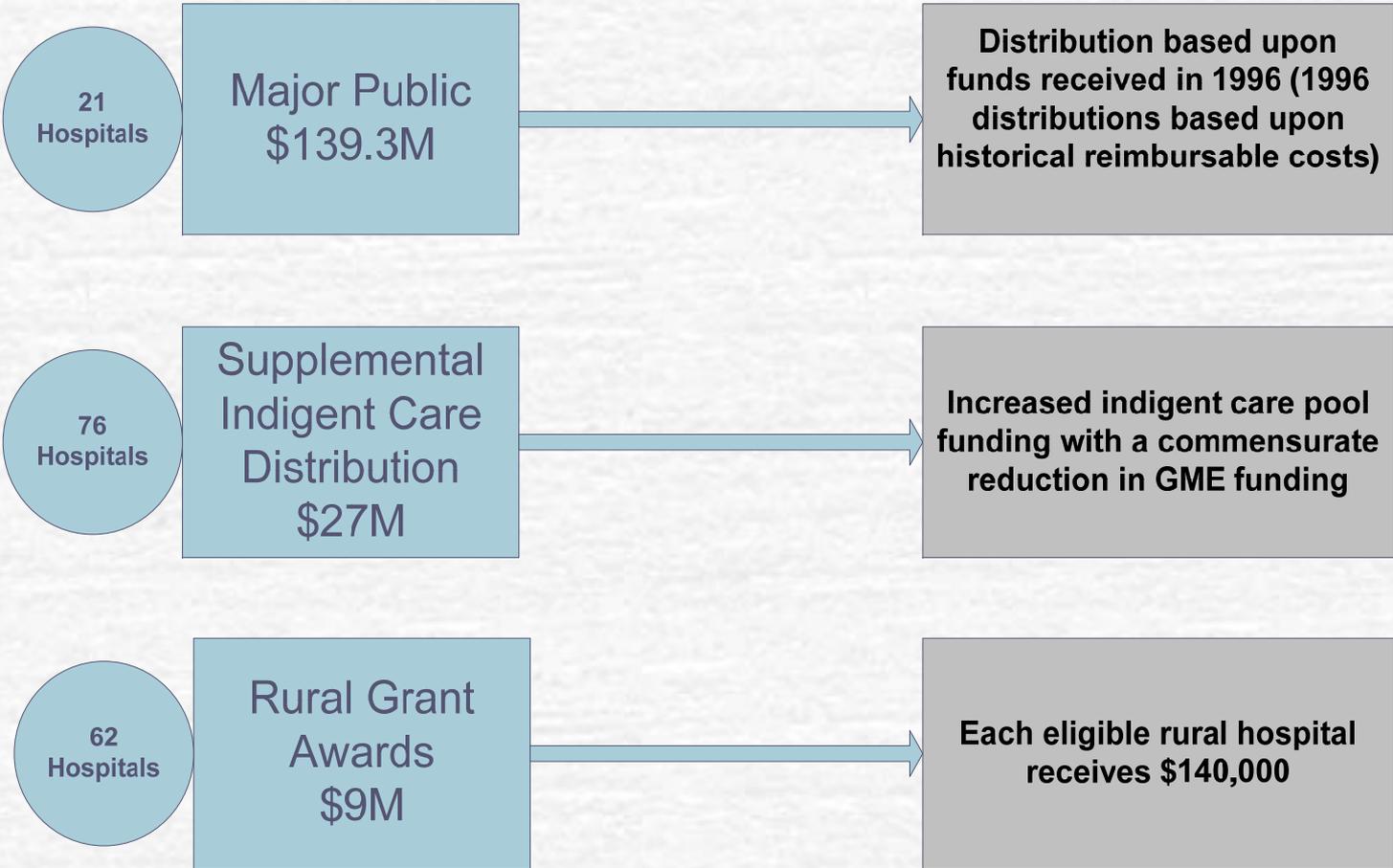
Calculation of Nominal Payment Amount and Distribution

Elements:			
Hospital Inpatient and Outpatient Uncompensated Care	\$ 4,500,000		
Hospital Inpatient and Outpatient Cost	\$ 100,000,000		
Targeted Need Percentage:	4.50%		
Targeted Need Percentage of Costs	Targeted Need	Statutory Coverage Ratio	Nominal Payment Amount
> 0% to < .5%	\$ 50,000	60%	30,000
>.5% to < 2%	\$ 1,500,000	65%	975,000
> 2% to < 3%	\$ 1,000,000	70%	700,000
> 3% to < 4%	\$ 1,000,000	75%	750,000
> 4% to < 5%	\$ 950,000	80%	760,000
> 5% to < 6%	\$ -	85%	-
> 6% to < 7%	\$ -	90%	-
> 7% to < 8%	\$ -	95%	-
>8%	\$ -	100%	-
Total	\$ 4,500,000		\$ 3,215,000
Resources Available			\$ 562,700,000
Total Voluntary Nominal Payment Amount (NPA)			773,364,486
Coverage Ratio of NPA			72.8%
Hospital Projected Distribution:			<u>\$ 2,339,234</u>

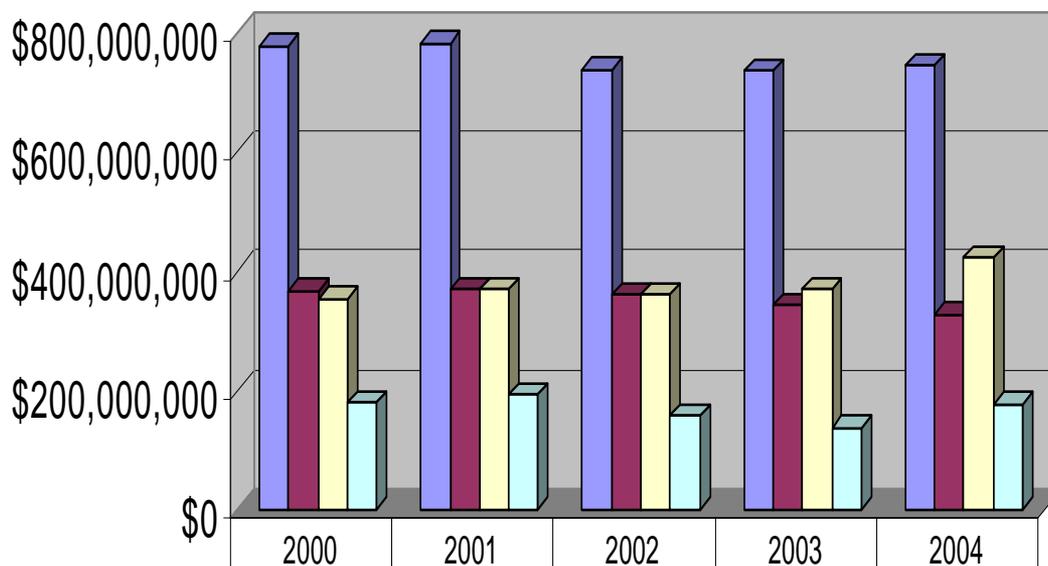
Distributions based upon Uncompensated Care Need



Distributions Based Upon Alternative Methodologies



Hospitals report almost twice as much Bad Debt as they do Charity Care for both Voluntary and Public Hospitals



	2000	2001	2002	2003	2004
■ Voluntary Bad Debt	\$778,224,217	\$782,337,475	\$737,721,911	\$737,213,829	\$745,976,366
■ Voluntary Charity	\$367,384,007	\$367,939,945	\$360,144,589	\$342,145,428	\$327,268,558
■ Public Bad Debt	\$354,393,899	\$370,086,323	\$360,726,490	\$369,315,812	\$422,719,699
■ Public Charity	\$178,075,167	\$191,092,261	\$156,089,898	\$135,740,796	\$176,424,386

Since 2000, voluntary hospitals on average have received in excess of 60 cents for each dollar of reported BDCC from the Indigent Care Pool

Pool Year	Pool Resources/Distributions	BDCC ⁽¹⁾	Overall Coverage Ratio
2000	\$707.7	\$ 1,031.2	68.6%
2001	\$707.7	\$ 1,138.6	62.2%
2002	\$707.7	\$ 1,145.6	61.8%
2003	\$707.7	\$ 1,151.3	61.5%
2004	\$707.7	\$ 1,086.7	65.1%
2005	\$707.7	\$ 1,080.6	65.5%
2006	\$707.7	\$ 1,073.2	65.9%

(In Millions)

(1) Based upon two year prior to pool year

Coverage ratios for individual voluntary hospitals range from 46% to 352% of reported uncompensated care need

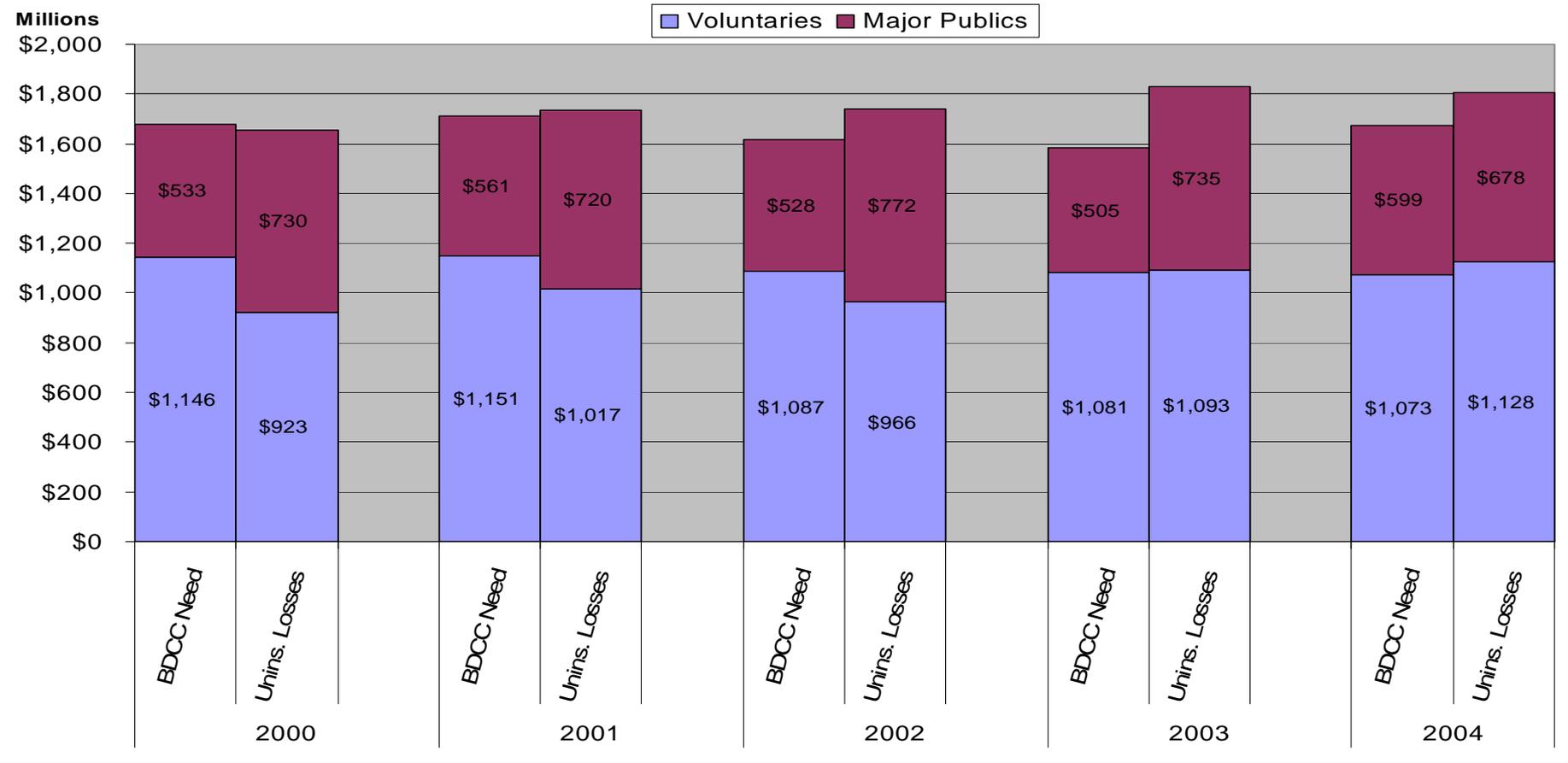
Since 2000, public hospitals on average have received in excess of 20 cents for each dollar of report BDCC from the Indigent Care Pool

	Pool Resources	BDCC	Coverage Ratio
Pool Year	Public	Public	Public (1)
2000	\$139.3	\$668.5	20.8%
2001	\$139.3	\$646.6	21.5%
2002	\$139.3	\$532.5	26.2%
2003	\$139.3	\$561.2	24.8%
2004	\$139.3	\$528.0	26.4%
2005	\$139.3	\$505.1	27.6%
2006	\$139.3	\$599.1	23.3%

(In Millions)

(1) Does not reflect supplemental payments totaling \$411M, which increases coverage ratio to over 100% in some cases

Reported Uninsured Losses Exceed Reported BDCC Need



- ❖ Consistent with PHL 2807-k(1)(e) for cost reporting purposes, uninsured is defined as patients without insurance or other third party coverage for the unit of service billed, including units of service, which, although provided to patients who are insured, are not covered. It shall not encompass instances of underinsurance for patients who may have some insurance
- ❖ Uninsured losses are determined as the difference between cost and revenue related to service provided to the uninsured patients for inpatient and outpatient services

Reported uninsured units of service

Category of Service	Voluntary Uninsured Units of Service ⁽¹⁾	Public Uninsured Units of Service ⁽¹⁾	Total Uninsured Units of Service
Inpatient			
Discharges	50,059	21,831	71,890
Exempt Patient Days	67,067	39,204	106,271
Emergency	696,117	335,237	1,031,354
Clinics ⁽²⁾	897,251	837,021	1,734,272

(1) Uninsured units of service based upon 2004 self pay and free (no-pay) statistics reported on the Institutional Cost Report

(2) Does not include such services as Ambulatory Surgery, Methadone, Renal Dialysis and specialty services that are reimbursed above the clinic rate (i.e. chemotherapy)

In addition to submitting the annual cost report (ICR) hospitals must comply with the following to participate in the indigent care pools

- Incur uncompensated care costs greater than .50% of the hospital inpatient and outpatient costs
- Provide an annual Independent CPA certification that their billing, collection and account write-off procedures are consistent with standards specified in a certification statement as prescribed by law and regulations
- Comply with the requirements established by the hospital patient financial aid law effective January 1, 2007

Hospital Patient Financial Aid Statute

- **Laws of 2006 added a new subdivision to Article 2807-k setting forth new requirements for participation in the indigent care pool for 2009**
- **The new requirements included minimum financial aid eligibility standards including:**
 - ✓ caps on fees charged (may not exceed higher of Medicare, Medicaid or highest volume commercial carrier)
 - ✓ collection efforts
 - ✓ reporting requirements
 - ✓ applies to uninsured individuals with household incomes < or equal to 300% of FPL
- **Services required to be covered by the financial aid policies include emergency services for all low income uninsured residents of New York and non-emergent medically necessary services in the hospitals' primary service area**
- **Hospitals are not obligated to provide financial aid to insured patients**

Hospital Patient Financial Aid Statute Discounting Requirements

Income Level	Cap
Below 100% of FPL	Minimum established by Commissioner
Between 101% and 150%	Sliding fee schedule in equal increments up to 20% of Medicare, Medicaid or commercial carrier rates
Between 151% and 250%	Sliding fee schedule in equal increments of the Medicare, Medicaid or commercial carrier rates
Between 251% and 300%	No more than Medicare, Medicaid or commercial carrier rates

Federal Poverty Level (FPL) : \$30,000 for Family of 4

Hospital Patient Financial Aid Statute

- **Adds new reporting requirements for hospitals effective January 1, 2007:**
 - ✓ Hospital costs incurred and uncollected amounts in providing services to eligible patient without insurance
 - ✓ Hospital costs incurred and uncollected amounts in providing services to eligible patient with insurance
 - ✓ Number of patients by zip code who applied for financial assistance
 - ✓ Reimbursement from the Indigent Care Pool
 - ✓ Funds expended from charitable bequests for the purpose of charity care
 - ✓ Where allowed, the number of Medicaid applications that hospitals assisted patients in completing
 - ✓ Hospital financial losses resulting from services provided under Medicaid
 - ✓ Number of liens placed on primary care residences through the hospitals collection process

Appendices

➤ **Appendix A**

- ✓ Technical Advisory Committee Members

➤ **Appendix B: Public Health Law**

- ✓ 2807-K
- ✓ 2807-W

➤ **Appendix C: Regulations**

- ✓ Part 86-1.11

➤ **Appendix D:**

- ✓ 2006 Indigent Care Model

➤ **Appendix E:**

- ✓ ICR Components
- ✓ Exhibits 32, 33, 46 & 47

KEY ISSUES FOR DISCUSSION

Indigent Care

Technical Advisory Committee

September 18, 2007

How should indigent care be defined for purposes of distributions from the Indigent Care Pool?

- ▣ **Should it be limited or prioritized to address services rendered to the uninsured? (We are using the term uninsured to mean individuals with no insurance and individuals who have no insurance for the services they require.)**
- ▣ **Should it include hospital losses associated with failure to collect co-pays and deductibles from otherwise insured patients?**
- ▣ **Should it exclude all other types of uncollected patient service receipts?**
- ▣ **Should it be limited to services rendered to patients who meet specified low-income thresholds (e.g. those provided under the new Patient Financial Aid mandate)?**

What should be the basis for calculating hospital subsidy awards?

- ▣ **Should accounting write-offs continue to be used as the primary basis for determining annual awards?**
- ▣ **linked to the actual units of service a hospital provides for targeted uncompensated care? Should uncompensated care to uninsured patients be treated for subsidy purposes the same as non-payment of co-pays and deductibles?**
- ▣ **Should actual hospital losses be subsidized at each hospital's costs or should it be based on a specified payment proxy (e.g. Medicaid rates)?**
- ▣ **Should out-of-pocket collections received from targeted uncompensated care populations be a factor in adjusting a calculated subsidy awards?**
- ▣ **Should a progressive scale continue to be used to increase subsidy levels for hospitals providing a greater proportion of uncompensated care relative to their total patient service volume?**

What other factors should be considered in determining a hospital's eligibility or their relative share of available annual subsidies?

- ▣ **Should there be a minimum level of uncompensated care a hospital needs to annually provide to be eligible for subsidies?**
- ▣ **If so, should care up to this level be subsidized?**
- ▣ **Should there continue to be subsets of available annual funding that increases subsidy coverage for certain categories of hospitals?**
- ▣ **If so, should subsidy determinations within these subsets be solely based on an uncompensated care award formula which is uniformly applied to all program components?**

What requirements should be considered to insure the accuracy of data to be used for subsidy award determination purposes?

- ▣ What is the minimum data hospitals should be required to report to secure funds from the indigent care pool?**
- ▣ Are there new data reporting requirements or readily available alternative data sources that need to be considered?**
- ▣ How can relevant data reported by hospitals be improved?**
- ▣ What are some reasonable procedures that can be considered to validate data accuracy?**

Reforming and Restructuring the Hospital Indigent Care Pool Methodology

New York State Department of Health
Commissioner Richard F. Daines, M.D.
November 14, 2007

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 $\frac{1}{2}$ 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 \leq 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 deductible 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

Total Funds Available
\$847M

\$139.3M
Major Public Allocation

Distribution to be based upon un-
insured units of service and Medicaid
rates applied to a progressive scale

\$26.5M
Rural Distribution

Distribution to be based upon uncompensated care
weighted by bed size applied to a progressive scale

\$681.2M
Excess for distribution to Voluntaries

85%

15%

\$579M

Allocation to be distributed based upon
uninsured units of service and Medicaid
rates applied to a progressive scale

\$102.2M

Allocation to be based upon cost of co-pay and deductibles
not paid by patients who qualify for financial aid policies

Section 2807-k. General Hospital Indigent Care Pool

1. Definitions. For purposes of this section, the following words or phrases shall have the following meanings, unless the context otherwise requires:

(a) "Major public general hospital" means all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

(b) "Nominal payment amount" shall mean the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to a scale.

(c) "Targeted need" shall mean the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the commissioner to general hospital inpatient and ambulatory services, excluding referred ambulatory services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period. Base year data and statistics for the calendar year two years prior to the distribution period shall be considered final, for purposes of this section, one hundred twenty days after hospitals receive the department's initial statewide rates for the same period as the distribution period and shall include any appropriate revisions reported by hospitals during such one hundred twenty days.

(d) "Uncompensated care need" means losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services. The cost of services provided as an employment benefit or as a courtesy shall not be included.

(e) "Uninsured care" means losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payments made directly to the general hospital and indemnity or similar payments made to the person who is a payor of hospital services. The cost of services denied reimbursement, other than emergency room services, for lack of medical necessity or lack of compliance with prior authorization requirements, or provided as an employment benefit, or as a courtesy shall not be included.

(f) "Ambulatory services" of a general hospital shall mean all services delivered on an ambulatory basis, including, for periods on and after January first, two thousand four, services provided at qualified hospital-controlled diagnostic and treatment centers except as otherwise provided in subdivision thirteen of this section.

(g) "Qualified hospital-controlled diagnostic and treatment center" shall mean a voluntary, non-profit diagnostic and treatment center providing a comprehensive range of primary health care services that is controlling, controlled by, or under common control with a general hospital, and as of June thirtieth, two thousand three:

(i) qualified for an allocation of funds pursuant to section twenty-eight hundred seven-p of this article or pursuant to section seven of chapter four hundred thirty-three of the laws of

nineteen hundred ninety-seven, as amended; or

(ii) the outpatient department of such general hospital had been designated a federally-qualified health center under section 330 of the Public Health Service Act (42 U.S.C. § 254b) and had directly received a grant under such section.

2. To the extent of funds appropriated therefor, funds shall be made available for distribution by or on behalf of the state in accordance with the following methodology, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law, from a general hospital indigent care pool established by the commissioner.

3.(a) Each major public general hospital shall be allocated for distribution from the pools established pursuant to this section for each year through December thirty-first, two thousand seven, an amount equal to the amount allocated to such major public general hospital from the regional pool established pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six.

(b) For the period January first, two thousand eight through March thirty-first, two thousand eight each major public general hospital shall be allocated for distribution from the pools established pursuant to this section for such period, an amount equal to one-quarter the amount calculated pursuant to paragraph (a) of this subdivision.

4. (a) From funds in the pool for each year, thirty-six million dollars shall be reserved on an annual basis through December thirty-first, two thousand seven and nine million dollars shall be reserved for the period January first, two thousand eight through March thirty-first, two thousand eight, for distribution as high need adjustments in accordance with subdivision six of this section.

(a-1) From funds in the pool for each year, twenty-seven million dollars shall be reserved on an annual basis for the periods January first, two thousand through December thirty-first, two thousand seven and six million seven hundred fifty thousand dollars shall be reserved for the period January first, two thousand eight through March thirty-first, two thousand eight, for distribution in accordance with subdivision sixteen of this section.

(b) The balance of funds in a pool not allocated in accordance with subdivision three of this section or reserved for distributions pursuant to subdivisions six and sixteen of this section shall be distributed to eligible general hospitals, excluding major public general hospitals, on the basis of each general hospital's targeted need share, adjusted for transition factors in accordance with subdivision seven of this section.

(c) To be eligible for distributions from the pool, a general hospital's targeted need must exceed one-half of one percent.

(d) For the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, each eligible general hospital's targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in subdivision five of this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available in the pool.

5. The scale utilized for development of each eligible general hospital's nominal payment

amount shall be as follows:

Percentage of Reimbursement Attributable to that Portion		
Targeted	Need Percentage	of Targeted Need
0	-.5%	60%
.5+	-2%	65%
2+	-3%	70%
3+	-4%	75%
4+	-5%	80%
5+	-6%	85%
6+	-7%	90%
7+	-8%	95%
8+		100%

6. Funds reserved for high need adjustments shall be distributed to general hospitals, excluding major public general hospitals, with nominal need in excess of four percent as follows: each general hospital's share of the reserved amount shall be based on such hospital's aggregate share of nominal need above four percent compared to the total aggregate nominal need above four percent of all eligible hospitals.

7. (a) Hospital specific transition adjustment. Notwithstanding any inconsistent provision of this section, distributions to general hospitals determined in accordance with subdivision four of this section shall be adjusted as follows:

(i) For general hospitals which qualified for distributions pursuant to paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article as of December thirty-first, nineteen hundred ninety-five:

(A) for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, each such general hospital shall receive as an allocation one hundred percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivisions fourteen-c and seventeen and paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six; and

(B) for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, each such general hospital shall receive as an allocation seventy-five percent of the amount determined in accordance with clause (A) of this subparagraph and twenty-five percent of the amount determined in accordance with subdivision four of this section; and

(C) for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, each such general hospital shall receive as an allocation fifty percent of the amount determined in accordance with clause (A) of this subparagraph and fifty percent of the amount determined in accordance with subdivision four of this section; and

(D) for the period January first, two thousand through December thirty-first, two thousand, each such general hospital shall receive as an allocation twenty-five percent of the amount determined in accordance with clause (A) of this subparagraph and seventy-five percent of

the amount determined in accordance with subdivision four of this section provided, however, that for any general hospital whose distribution is greater when determined solely in accordance with subdivisions four and six of this section than when determined according to this clause, such general hospital's distribution shall not be adjusted pursuant to this clause; and

(E) for periods on and after January first, two thousand one, each such general hospital shall receive as an allocation one hundred percent of the amount determined in accordance with subdivision four of this section.

(ii) For all other general hospitals, excluding major public general hospitals, general hospitals qualifying for an adjustment pursuant to subparagraph (i) of this paragraph, general hospitals which qualified for an adjustment pursuant to subdivision fourteen-d of section twenty-eight hundred seven-c of this article and rural general hospitals that met the qualifications as a rural general hospital pursuant to paragraph (f) of subdivision four of section twenty-eight hundred seven-c of this article in nineteen hundred ninety-six:

(A) for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, each such general hospital shall receive as an allocation fifty percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six and fifty percent of the amount determined in accordance with subdivision four of this section; and

(B) for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, each such general hospital shall receive as an allocation twenty-five percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six and seventy-five percent of the amount determined in accordance with subdivision four of this section.

(b) Hospital category adjustment. Notwithstanding any inconsistent provision of this section, distributions to each general hospital, excluding major public general hospitals, for nineteen hundred ninety-seven determined in accordance with subdivision four of this section and paragraph (a) of this subdivision within the categories specified in subparagraph (i) of this paragraph shall be adjusted in accordance with subparagraph (ii) of this paragraph.

(i)(A) General hospitals that qualified for distributions in accordance with subdivision fourteen-d of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six.

(B) Rural general hospitals that met the qualifications as a rural general hospital pursuant to paragraph (f) of subdivision four of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six.

(C) All other general hospitals, excluding general hospitals that qualified for distributions pursuant to paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article.

(ii) For each category specified in subparagraph (i) of this paragraph, fifty percent of the amount by which the allocation pursuant to subdivision four of this section and paragraph (a) of this subdivision to a general hospital within such category exceeds the projected distribution, as of June first, nineteen hundred ninety-seven, pursuant to subdivision seventeen and, if applicable, subdivision fourteen-d of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six to such general hospital shall be reserved by

the commissioner for allocation to general hospitals within such category that would experience a loss based on such comparison based on each such general hospital's proportionate share of the aggregate losses for all general hospitals within such category; provided however, that the amount reserved within a category shall not exceed the aggregate amount of losses within such category.

8. Notwithstanding any inconsistent provision of this section, up to five percent of the amount allocated for each of the periods for distributions pursuant to this section may be transferred by the commissioner, to the extent of funds appropriated therefor, and allocated for distributions pursuant to the child health insurance plan established pursuant to title one-A of article twenty-five of this chapter.

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must implement minimum collection policies and procedures approved by the commissioner and must be in compliance with bad debt and charity care reporting requirements established pursuant to this article.

9-a. (a) As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand seven, establish financial aid policies and procedures, in accordance with the provisions of this subdivision, for reducing charges otherwise applicable to low-income individuals without health insurance, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts.

(b) Such reductions from charges for uninsured patients with incomes below at least three hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

(i) For patients with incomes at or below at least one hundred percent of the federal poverty level, the hospital shall collect no more than a nominal payment amount, consistent with guidelines established by the commissioner;

(ii) For patients with incomes between at least one hundred one percent and one hundred fifty percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases from the nominal amount described in subparagraph (i) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid);

(iii) For patients with incomes between at least one hundred fifty-one percent and two hundred fifty percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which

patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the twenty percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid); and

(iv) For patients with incomes between at least two hundred fifty-one percent and three hundred percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid).

(v) For the purposes of this paragraph, "highest volume payor" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.

(vi) A hospital may implement policies and procedures to permit, but not require, consideration on a case-by-case basis of exceptions to the requirements described in subparagraphs (i) and (ii) of this paragraph based upon the existence of significant assets owned by the patient that should be taken into account in determining the appropriate payment amount for that patient's care, provided, however, that such proposed policies and procedures shall be subject to the prior review and approval of the commissioner and, if approved, shall be included in the hospital's financial assistance policy established pursuant to this section, and provided further that, if such approval is granted, the maximum amount that may be collected shall not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid). In the event that a general hospital reviews a patient's assets in determining payment adjustments such policies and procedures shall not consider as assets a patient's primary residence, assets held in a tax-deferred or comparable retirement savings account, college savings accounts, or cars used regularly by a patient or immediate family members.

(vii) Nothing in this paragraph shall be construed to limit a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified herein and/or to provide greater payment discounts for eligible patients than those required by this paragraph.

(c) Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures upon request. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the notification of patients during the intake and registration

process, through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.

(d) Such policies and procedures shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the hospital's financial assistance policy. The monthly payment under such a plan shall not exceed ten percent of the gross monthly income of the patient, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed the rate for a ninety-day security issued by the United States Department of Treasury, plus .5 percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.

(e) Such policies and procedures shall permit patients to apply for assistance within at least ninety days of the date of discharge or date of service and provide at least twenty days for patients to submit a completed application. Such policies and procedures may require that patients seeking payment adjustments provide appropriate financial information and documentation in support of their application, provided, however, that such application process shall not be unduly burdensome or complex. General hospitals shall, upon request, assist patients in understanding the hospital's policies and procedures and in applying for payment adjustments. Application forms shall be printed in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency necessary for effective communication with health care providers, or (ii) spoken by non-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. Such policies and procedures shall require that the hospital issue any denial/approval of such application in writing with information on how to appeal the denial and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first applying for coverage under title XIX of the social security act (medicaid) or another insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another

insurance program, and upon the patient's cooperation in following the hospital's financial assistance application requirements, including the provision of information needed to make a determination on the patient's application in accordance with the hospital's financial assistance policy.

(f) Such policies and procedures shall provide that patients with incomes below three hundred percent of the federal poverty level are deemed presumptively eligible for payment adjustments and shall conform to the requirements set forth in paragraph (b) of this subdivision, provided, however, that nothing in this subdivision shall be interpreted as precluding hospitals from extending such payment adjustments to other patients, either generally or on a case-by-case basis. Such policies and procedures shall provide financial aid for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (42 USC 1395dd), to patients who reside in New York state and for medically necessary hospital services for patients who reside in the hospital's primary service area as determined according to criteria established by the commissioner. In developing such criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. Such criteria shall be made available to the public no less than thirty days prior to the date of implementation and shall, at a minimum:

(i) prohibit a hospital from developing or altering its primary service area in a manner designed to avoid medically underserved communities or communities with high percentages of uninsured residents;

(ii) ensure that every geographic area of the state is included in at least one general hospital's primary service area so that eligible patients may access care and financial assistance; and

(iii) require the hospital to notify the commissioner upon making any change to its primary service area, and to include a description of its primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-l of this article.

(g) Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's primary service area. For patients determined to be eligible for financial aid under the terms of a hospital's financial aid policy, such policies and procedures shall prohibit any limitations on financial aid for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

(h) Such policies and procedures shall not permit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall require the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. Such policies and procedures shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection agency obtain the hospital's written consent prior to commencing a legal action. Such policies and procedures shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in such policies and procedures, and require the implementation of a mechanism for the general hospital to measure its compliance with such policies and procedures. Such policies and procedures shall require that any collection agency under contract with a general hospital for the collection of debts follow the hospital's financial assistance policy, including

providing information to patients on how to apply for financial assistance where appropriate. Such policies and procedures shall prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services medicaid payment is available.

(i) Reports required to be submitted to the department by each general hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

(i) a report on hospital costs incurred and uncollected amounts in providing services to eligible patients without insurance, including the amount of care provided for a nominal payment amount, during the period covered by the report;

(ii) hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;

(iii) the number of patients, organized according to United States postal service zip code, who applied for financial assistance pursuant to the hospital's financial assistance policy, and the number, organized according to United States postal service zip code, whose applications were approved and whose applications were denied;

(iv) the reimbursement received for indigent care from the pool established pursuant to this section;

(v) the amount of funds that have been expended on charity care from charitable bequests made or trusts established for the purpose of providing financial assistance to patients who are eligible in accordance with the terms of such bequests or trusts;

(vi) for hospitals located in social services districts in which the district allows hospitals to assist patients with such applications, the number of applications for eligibility under title XIX of the social security act (medicaid) that the hospital assisted patients in completing and the number denied and approved;

(vii) the hospital's financial losses resulting from services provided under medicaid; and

(viii) the number of liens placed on the primary residences of patients through the collection process used by a hospital.

(j) Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material which is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility.

10. In order for a general hospital to be eligible for distribution of funds from the pool, such general hospital if it provides obstetrical care and services must be in compliance with the provisions of paragraph (e) of subdivision sixteen of section twenty-eight hundred seven-c of this article.

11. Minimum hospital procedures to determine the availability of insurance or other third-

party coverage for hospital services shall be specified by the commissioner.

12. Each general hospital shall submit reports to the department at such time and in such form as the commissioner shall require of:

(a) hospital costs incurred and uncollected amounts in providing services to the uninsured during the period covered by the report; and

(b) hospital costs incurred and uncollected amounts for deductibles and coinsurance for patients with insurance or other third-party payor coverage.

(c) Such reports shall comply with the reporting requirements established for receipt of bad debt and charity care pool payments as provided in accordance with section twenty-eight hundred seven-c of this article and regulations promulgated thereunder for periods prior to January first, nineteen hundred ninety-seven.

13. Distributions to general hospitals pursuant to this section and the adjustments provided in accordance with subdivision fourteen-f of section twenty-eight hundred seven-c of this article shall be considered disproportionate share payments for inpatient hospital services to general hospitals serving a disproportionate number of low income patients with special needs for purposes of providing assurances to the secretary of health and human services as necessary to meet federal requirements for securing federal financial participation pursuant to title XIX of the federal social security act.

14. Notwithstanding any inconsistent provision of law to the contrary, the availability or payment of funds to a general hospital pursuant to this section shall not be admissible as a defense, offset or reduction in any action or proceeding relating to any bill or claim for amounts due for hospital services provided.

15. Revenue from distributions pursuant to this section and adjustments pursuant to subdivision fourteen-f of section twenty-eight hundred seven-c of this article shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

16. Supplemental indigent care distributions. From available resources established pursuant to paragraph (a-1) of subdivision four of this section, each hospital shall receive a proportionate share, provided that no hospital shall receive less than the reduction amount calculated pursuant to paragraph (d) of subdivision three of section twenty-eight hundred seven-m of this article, subject to hospital specific disproportionate share payment limits calculated in accordance with subdivision twenty-one of section twenty-eight hundred seven-c of this article.

Revised: April 2008

Section 2807-w. High Need Indigent Care Adjustment Pool

Funds allocated pursuant to paragraph (p) of subdivision one of section twenty-eight hundred seven-v of this article, shall be deposited as authorized and used for the purpose of making medicaid disproportionate share payments of up to eighty-two million dollars on an annualized basis pursuant to subdivision twenty-one of section twenty-eight hundred seven-c of this article, for the period January first, two thousand through March thirty-first, two thousand eight, in accordance with the following:

1. From the funds in the pool each year: (a) Each eligible rural hospital shall receive one hundred forty thousand dollars on an annualized basis for the periods January first, two thousand through December thirty-first, two thousand seven and thirty-five thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this paragraph exceeds a hospital's applicable disproportionate share limit, then the total amount in excess of such limit shall be provided as a nondisproportionate share payment in the form of a grant directly from this pool without allocation to the special revenue funds - other, indigent care fund - 068, or any successor fund or account;

(b) Each such hospital shall also receive an amount calculated by multiplying the facility's uncompensated care need by the appropriate percentage from the following scale based on hospital rankings developed in accordance with each eligible rural hospital's weight as defined by this section.

Rank	Percentage Coverage of Uncompensated Care Need
1-9	60.0%
10-17	52.5%
18-25	45.0%
26-33	37.5%
34-41	30.0%
42-49	22.5%
50-57	15.0%
58+	7.5%

For purposes of calculating the distribution amount to an eligible rural hospital which has merged with another hospital on or after December thirty-first, nineteen hundred ninety-nine, and continues to be an eligible rural hospital in accordance with paragraph (c) of this subdivision, such merged facility's uncompensated care need pursuant to this paragraph shall be calculated from data provided in the eligible rural hospital's institutional cost report filed for the rate period two years prior to the distribution period, or if such report is not required for such rural hospital, the distribution amount shall be based upon the last institutional cost report required to be filed by such rural hospital.

(c) "Eligible rural hospital", as used in this section, shall mean a general hospital that as of December thirty-first, nineteen hundred ninety-nine or thereafter, was classified as a rural

hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, or a general hospital, which during the same time period, had a service area which has an average population of less than one hundred seventy-five persons per square mile, or a general hospital which has a service area which has an average population of less than two hundred persons per square mile measured as population density by zip code. The average population of the service area is calculated by multiplying annual patient discharges by the population density per square mile of the county of origin or zip code as applicable for each patient discharge and dividing by total discharges. Annual patient discharges shall be determined using discharge data for the nineteen hundred ninety-seven rate year, as reported to the commissioner by October first, nineteen hundred ninety-eight. Population density shall be determined utilizing United States census bureau data for nineteen hundred ninety-seven. If an eligible rural hospital merges with another general hospital, on or after December thirty-first, nineteen hundred ninety-nine, and the merger results in separate facilities operating under a single facility operating certificate, such eligible rural hospital shall continue to be a separate eligible rural hospital for purposes of this subdivision until June thirtieth, two thousand three, and payments provided in accordance with this section shall be made to the merged entity; provided, however, that payments shall only be made to the merged entity if such separate eligible rural hospital continues to provide inpatient and/or outpatient hospital services at the same location at which it operated prior to the merger. If an eligible rural hospital merges with another general hospital on or after December thirty-first, nineteen hundred ninety-nine, and the merger results in such rural hospital continuing to operate under a separate facility operating certificate, such rural hospital will continue to be an eligible rural hospital after the merger; provided, however, that payments shall only be made to such rural hospital if such eligible rural hospital continues to provide inpatient and/or outpatient hospital services at the same location at which it is operated prior to the merger.

(d) "Eligible rural hospital weight", as used in this section, shall mean the result of adding, for each eligible rural hospital:

(i) The eligible rural hospital's targeted need, as defined in section twenty-eight hundred seven-k of this article, minus the mean targeted need for all eligible rural hospitals, divided by the standard deviation of the targeted need of all eligible rural hospitals; and

(ii) The mean number of beds of all eligible rural hospitals minus the number of beds for an individual hospital, divided by the standard deviation of the number of beds for all eligible rural hospitals.

2. From the funds in the pool each year, thirty-six million dollars on an annualized basis for the periods January first, two thousand through December thirty-first, two thousand seven and nine million dollars for the period January first, two thousand eight through March thirty-first, two thousand eight, of the funds not distributed in accordance with subdivision one of this section, shall be distributed in accordance with the formula set forth in subdivision six of section twenty-eight hundred seven-k of this article.

3. From the funds in the pool each year, any funds not distributed in accordance with subdivision one or two of this section, shall be distributed in accordance with the formula set forth in paragraph (b) of subdivision four of section twenty-eight hundred seven-k of this article.

4. In order for a general hospital to be eligible to participate in the distribution of funds pursuant to this section, such general hospital must be in compliance with the provisions of subdivisions nine, ten and twelve of section twenty-eight hundred seven-k of this article.

Revised: April 2008

Section 2807-p. Comprehensive Diagnostic And Treatment Centers Indigent Care Program

1. (a) For periods prior to July first, two thousand three, and on and after July first, two thousand five the commissioner is authorized to make payments to eligible diagnostic and treatment centers, to the extent of funds available therefor, up to forty-eight million dollars annually, to assist in meeting losses resulting from uncompensated care. The amount of funds available for such payments pursuant to subdivision four of this section shall be the amount remaining after the allocation provided in section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven as amended by section seventy-five of chapter one of the laws of nineteen hundred ninety-nine.

(b) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment to assist in meeting losses resulting from uncompensated care, provided, however, in the event federal financial participation is not available, the commissioner is authorized to continue to make payments to eligible diagnostic and treatment centers, to the extent of funds available therefor, in accordance with provisions of paragraph (a) of this subdivision and without regard to the provisions of subdivisions four-a and four-b of this section.

2. Definitions. (a) "Eligible diagnostic and treatment centers", for purposes of this section, shall mean voluntary non-profit and publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate losses from disproportionate share of uncompensated care during a base period two years prior to the grant period; provided that for periods on and after January first, two thousand four an eligible diagnostic and treatment center shall not include any voluntary non-profit diagnostic and treatment center controlling, controlled by or under common control with a health maintenance organization, as defined by subdivision one of section forty-four hundred one of this chapter; provided further that for purposes of this section, a health maintenance organization shall not include a prepaid health services plan licensed pursuant to section forty-four hundred three-a of this chapter. For periods on and after July first, two thousand three, the base period and the grant period shall be the calendar year.

(b) "Uncompensated care need", for purposes of this section, means losses from reported self-pay and free visits multiplied by the facility's medical assistance payment rate for the applicable distribution year, offset by payments received from such patients during the reporting period.

3. (a) During the period January first, nineteen hundred ninety-seven through September thirtieth, nineteen hundred ninety-seven and for each fiscal year period commencing on October first thereafter through December thirty-first, nineteen hundred ninety-nine and for periods on and after January first, two thousand, diagnostic and treatment centers shall be eligible for allocations of funds or for rate adjustments determined in accordance with this section to reflect the needs of the diagnostic and treatment center for the financing of losses resulting from uncompensated care.

(b) A diagnostic and treatment center qualifying for a distribution or a rate adjustment pursuant to this section shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third-party insurance payors, governmental payors and self-paying patients.

(c) To be eligible for an allocation of funds or a rate adjustment pursuant to this section, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of five percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The commissioner may retrospectively reduce the allocations of funds or the rate adjustments to a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the grant period in the delivery of comprehensive primary health care services to uncompensated care residents of the community.

4. (a) (i) The total amount of funds to be allocated and distributed for uncompensated care to eligible voluntary non-profit diagnostic and treatment centers for a distribution period prior to July first, two thousand three, and on and after July first, two thousand five through December thirty-first, two thousand six, in accordance with this subdivision shall be limited to thirty-three percent of the funds available therefor pursuant to paragraph (a) of subdivision one of this section and, for the period January first, two thousand seven through December thirty-first, two thousand seven, such distributions shall be limited to sixteen and one-half percent of the funds available therefor.

(ii) The total amount of funds to be allocated and distributed for uncompensated care to eligible publicly sponsored diagnostic and treatment centers for a grant period prior to July first, two thousand three, and on and after July first, two thousand five through December thirty-first, two thousand six, in accordance with this subdivision shall be limited to sixty-seven percent of funds available therefor pursuant to paragraph (a) of subdivision one of this section and, for the period January first, two thousand seven through December thirty-first, two thousand seven, such distributions shall be limited to thirty-three and one-half percent of the funds available therefor; provided, however, that for periods up through December thirty-first, two thousand seven, forty-one percent of the amount of funds allocated for distribution to eligible publicly sponsored diagnostic and treatment centers shall be available for clinics operating under the auspices of the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended.

(iii) (A) Notwithstanding any inconsistent provision of this paragraph, for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and for periods on and after January first, two thousand through December thirty-first, two thousand two, and for periods on and after January first, two thousand four through December thirty-first, two thousand seven, in the event that federal financial participation is not available for rate adjustments pursuant to this section, diagnostic and treatment centers which received an allowance pursuant to paragraph (f) of subdivision two of section twenty-eight hundred seven of this article for the period through December thirty-first, nineteen hundred ninety-six shall receive an annual uncompensated care distribution allocation of funds of not less than the amount that would have been received for any losses associated with the delivery of bad debt and charity care for nineteen hundred ninety-five had the provisions of paragraph (f) of subdivision two of section twenty-eight hundred seven of this article remained in effect, provided, however, that for the period January first, two thousand seven through December thirty-first, two thousand seven, the dollar value of the application of the provisions of this subparagraph for any such diagnostic and treatment center shall be reduced by fifty percent.

(B) For the period January first, two thousand three through June thirtieth, two thousand three, and for the period July first, two thousand three through December thirty-first, two thousand three and in the event that federal financial participation is not available for rate adjustments pursuant to this section, each such diagnostic and treatment center shall

receive an uncompensated care distribution allocation of funds of not less than one-half the amount calculated pursuant to clause (A) of this subparagraph.

(b) (i) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(ii) For periods prior to January first, two thousand eight, if the sum of the nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers or for all eligible public diagnostic and treatment centers or for all clinics operating under the auspices of the New York city health and hospitals corporation is less than the amount allocated for uncompensated care allowances pursuant to paragraph (a) of this subdivision for such diagnostic and treatment centers respectively, the nominal coverage percentages of base year period losses associated with the delivery of uncompensated care pursuant to this scale may be increased to not more than one hundred percent for voluntary non-profit diagnostic and treatment centers or for public diagnostic and treatment centers or for all clinics operating under the auspices of the New York city health and hospitals corporation in accordance with rules and regulations adopted by the council and approved by the commissioner.

(c) For periods prior to January first, two thousand eight, the uncompensated care allocations of funds for each eligible voluntary non-profit diagnostic and treatment center, as computed in accordance with paragraph (a) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for voluntary non-profit diagnostic and treatment centers pursuant to paragraph (a) of this subdivision to the total statewide nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

(d) For periods prior to January first, two thousand eight, the uncompensated care allocations of funds for each eligible public diagnostic and treatment center, other than clinics operating under the auspices of the New York city health and hospitals corporation and as computed in accordance with paragraph (a) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, pursuant to paragraph (a) of this subdivision to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

(e) For periods prior to January first, two thousand eight, the uncompensated care grant

allocations of funds for each eligible public diagnostic and treatment center operating under the auspices of the New York city health and hospitals corporation, as computed in accordance with paragraph (a) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation pursuant to paragraph (a) of this subdivision to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

(f) For periods prior to January first, two thousand eight, any residual amount allocated for distribution to a classification of diagnostic and treatment centers in accordance with this subdivision shall be reallocated by the commissioner for distributions to the other classifications based on remaining need.

(g) For periods on and after January first, two thousand seven, the uncompensated care allocations of funds for each eligible diagnostic and treatment center, other than allocations made pursuant to paragraphs (c), (d), (e) or (f) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for all eligible diagnostic and treatment centers to the total statewide nominal payment amounts for all eligible diagnostic and treatment centers determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

4-a. (a)(i) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payments made pursuant to paragraph (b) of subdivision one of this section for eligible voluntary non-profit diagnostic and treatment centers in accordance with subparagraphs (ii) and (iii) of this paragraph, for the following periods in the following aggregate amounts:

(A) For the period July first, two thousand three through December thirty-first, two thousand three, up to seven million five hundred thousand dollars;

(B) For the period January first, two thousand four through December thirty-first, two thousand four, up to fifteen million dollars;

(C) For the period January first, two thousand five through June thirtieth, two thousand five, up to seven million five hundred thousand dollars.

(ii) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(iii) The uncompensated care rate adjustments for each eligible voluntary non-profit diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for voluntary non-profit diagnostic and treatment centers pursuant to subparagraph (i) of this paragraph, to the total statewide nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers determined in accordance with subparagraph (ii) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(b)(i) For periods on and after July first, two thousand three through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payments made pursuant to paragraph (b) of subdivision one of this section for eligible public diagnostic and treatment centers, other than clinics operated under the auspices of the New York city health and hospitals corporation, in accordance with subparagraphs (ii) and (iii) of this paragraph, for the following periods in the following aggregate amounts:

(A) For the period July first, two thousand three through December thirty-first, two thousand three, up to nine million dollars;

(B) For the period January first, two thousand four through December thirty-first, two thousand four, up to eighteen million dollars;

(C) For the period January first, two thousand five through June thirtieth, two thousand five, up to nine million dollars.

(ii) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(iii) The uncompensated care rate adjustments for each eligible public diagnostic and treatment center, other than clinics operating under the auspices of the New York city health and hospitals corporation, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, pursuant to subparagraph (i) of this paragraph to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, determined in accordance with subparagraph (ii) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(c)(i) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payments made pursuant to paragraph (b) of subdivision one of this section for eligible public diagnostic and

treatment centers operating under the auspices of the New York city health and hospitals corporation, in accordance with subparagraphs (ii) and (iii) of this paragraph, for the following periods in the following aggregate amounts:

(A) For the period July first, two thousand three through December thirty-first, two thousand three, up to six million dollars;

(B) For the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million dollars;

(C) For the period January first, two thousand five through June thirtieth, two thousand five, up to six million dollars.

(ii) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits	% of nominal financial to total visits loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(iii) The uncompensated care rate adjustment, for each eligible public diagnostic and treatment center operating under the auspices of the New York city health and hospitals corporation shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation pursuant to subparagraph (i) of this paragraph to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation determined in accordance with subparagraph (ii) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(d) (i) Notwithstanding the provisions of paragraph (b) of this subdivision and any other provisions of this chapter, municipalities which received state aid pursuant to article two of this chapter for the nineteen hundred eighty-nine--nineteen hundred ninety state fiscal year in support of non-hospital based free-standing or local health department operated general medical clinics shall receive an uncompensated care rate adjustment for the period July first, two thousand three through December thirty-first, two thousand three, of not less than one-half the amount received in the nineteen hundred eighty-nine--nineteen hundred ninety state fiscal year for general medical clinics.

(ii) For the period January first, two thousand four through December thirty-first, two thousand four, each such municipality shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to subparagraph (i) of this paragraph.

(iii) For the period January first, two thousand five through June thirtieth, two thousand five, each such municipality shall receive an annual uncompensated care rate adjustment of not less than the amount calculated pursuant to subparagraph (i) of this paragraph.

(e) (i) Notwithstanding any inconsistent provision of this subdivision, for the period July first, two thousand three through December thirty-first, two thousand three, diagnostic and treatment centers which received an allowance pursuant to paragraph (f) of subdivision two of section twenty-eight hundred seven of this article for the period through December thirty-first, nineteen hundred ninety-six shall receive an uncompensated care rate adjustment of not less than one-half the amount that would have been received for any losses associated with the delivery of bad debt and charity care for nineteen hundred ninety-five had the provisions of paragraph (f) of subdivision two of section twenty-eight hundred seven of this article remained in effect.

(ii) For the period January first, two thousand four through December thirty-first, two thousand four, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to subparagraph (i) of this paragraph.

(iii) For the period January first, two thousand five through June thirtieth, two thousand five, each such diagnostic and treatment center shall receive an annual uncompensated care rate adjustment of not less than the amount calculated pursuant to subparagraph (i) of this paragraph, and shall be subject to subsequent adjustment or reconciliation.

(f) Any residual amount allocated for distribution to a classification of diagnostic and treatment centers in accordance with this subdivision shall be reallocated by the commissioner for distributions to the other classifications based on remaining need.

4-b. (a) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payment made pursuant to paragraph (b) of subdivision one of this section for eligible diagnostic and treatment centers with less than two years of operating experience, and diagnostic and treatment centers which have received certificate of need approval on applications which indicate a significant increase in uninsured visits, for the following periods and in the following aggregate amounts:

(i) For the period July first, two thousand three through December thirty-first, two thousand three, up to one million five hundred thousand dollars;

(ii) For the period January first, two thousand four through December thirty-first, two thousand four, up to three million dollars;

(iii) For the period January first, two thousand five through June thirtieth, two thousand five, up to one million five hundred thousand dollars.

(b) To be eligible for a rate adjustment pursuant to this section, a diagnostic and treatment center shall be a voluntary, non-profit or publicly sponsored diagnostic and treatment center providing a comprehensive range of primary health care services and be eligible to receive a medicaid budgeted rate prior to April first of the applicable rate adjustment period after which time, the department shall issue rate adjustments pursuant to this subdivision for such periods. Rate adjustments made pursuant to this subdivision shall be allocated based upon each eligible facility's proportional share of costs for services rendered to uninsured patients which have otherwise not been used for establishing distributions pursuant to subdivision four-a of this section. For the purposes of this subdivision costs shall be measured by multiplying each facility's medicaid budgeted rate by the estimated number of visits reported for services anticipated to be rendered to uninsured patients meeting the aforementioned criteria, less any anticipated patient service revenues received from such uninsured patients, during the applicable rate adjustment period.

4-c. Notwithstanding any provision of law to the contrary, the commissioner shall make additional payments for uncompensated care to voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, in the amount of seven million five hundred thousand dollars, and for the period January first, two thousand seven through December thirty-first, two thousand seven, seven million five hundred thousand dollars, and for the period January first, two thousand eight through March thirty-first, two thousand eight, in the amount of one million eight hundred seventy-five thousand dollars, provided, however, that for periods on and after January first, two thousand eight, such additional payments shall be distributed to voluntary, non-profit diagnostic and treatment centers and to public diagnostic and treatment centers in accordance with paragraph (g) of subdivision four of this section. In the event that federal financial participation is available for rate adjustments pursuant to this section, the commissioner shall make such payments as additional adjustments to rates of payment for voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four-a of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, fifteen million dollars in the aggregate, and for the period January first, two thousand seven through June thirtieth, two thousand seven, seven million five hundred thousand dollars in the aggregate. The amounts allocated pursuant to this paragraph shall be aggregated with and distributed pursuant to the same methodology applicable to the amounts allocated to such diagnostic and treatment centers for such periods pursuant to subdivision four of this section if federal financial participation is not available, or pursuant to subdivision four-a of this section if federal financial participation is available. Notwithstanding section three hundred sixty-eight-a of the social services law, there shall be no local share in a medical assistance payment adjustment under this subdivision.

5. Diagnostic and treatment centers shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality, access to, effectiveness and efficiency of uncompensated care provided. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable diagnostic and treatment centers to fairly and accurately determine and report uncompensated care visits and the costs of uncompensated care. In order to be eligible for an allocation of funds pursuant to this section, a diagnostic and treatment center must be in compliance with uncompensated care reporting requirements.

6. Notwithstanding any inconsistent provision of law to the contrary, the availability or payment of funds to a diagnostic and treatment center pursuant to this section shall not be admissible as a defense, offset or reduction in any action or proceeding relating to any bill or claim for amounts due for services provided by a diagnostic and treatment center.

7. Revenue from distributions to a diagnostic and treatment center pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

8. (a) For periods on or after January first, two thousand through June thirtieth, two thousand three, payments made to an eligible diagnostic and treatment center pursuant to this section shall be reduced or increased by an amount equal to the amount of any overpayments or underpayments made against grants awarded pursuant to section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven for the period three years prior to the annual awards made pursuant to this section.

(b) The determination of such overpayments or underpayments shall be based on the submission by eligible facilities of reports reflecting actual uncompensated care data, as required by the commissioner, which are attributable to prior periods. Submission of such reports is a condition for an eligible facility's receipt of payments pursuant to this section.

(c) For any periods in which a facility does not receive payments pursuant to this section, the amount of any prior period overpayment may be offset against payments for medical assistance made to such facility pursuant to title eleven of article five of the social services law and credited to funds allocated pursuant to this section. Any prior period underpayment to an eligible facility may be paid to such facility in a subsequent period.

9. Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation, provided, however, that in the event such adjustments are made as aggregate payments, then notwithstanding any law, rule or regulation to the contrary responsibility for the local share of such aggregate payments shall be apportioned to a local social services district based on the most recent geographic utilization data available to the department for eligible diagnostic and treatment center services for payments in accordance with subdivisions four-a and four-b of this section for all diagnostic and treatment center services provided in accordance with section three hundred sixty-five-a of the social services law, regardless of whether another social services district or the department may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.

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