

New York State Indigent Care Pool Workgroup Report

February 2019

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NYS Indigent Care Pool (ICP) Workgroup Report

I. Executive Summary

Created through Public Health Law, the Indigent Care Pool (ICP) is a program which provides funding to hospitals to assist in paying for the cost of care for low income individuals. The Pool currently distributes \$795 million dollars annually and is part of the larger Disproportionate Share Hospital (DSH) Program run by the Department of Health (Department). Under this program, hospitals cannot exceed their Federally established DSH caps, and currently, only public facilities are paid up to their facility-specific caps.

The total amount of DSH funding in New York is \$3.6 billion, of which \$2.8 billion is distributed to public hospitals under programs other than the ICP. New York State is currently facing the prospect of a reduction in overall DSH funding of \$1.3 billion in October 2019 and an annual reduction of \$2.6 billion by federal fiscal year 2021. These reductions in DSH funding have been postponed by Congress several times, but there continues to be considerable uncertainty about the future level of DSH funding.

The State Fiscal Year (SFY) 2018-19 Budget established the Indigent Care Workgroup with various stakeholders from the health care community. The purpose of Indigent Care Workgroup was to review the current methodology utilized by the Department to distribute funding to eligible hospitals throughout New York State. This effort was a follow-up to work previously done by a 2012 Workgroup which updated the ICP distribution methodology consistent with changes at the Federal level and established a transition methodology sometimes referred to as “a collar”. The collar set a minimum and maximum amount facilities could receive as they moved to the new methodology. The transition collar was originally scheduled to phase out by December 31, 2015, but it has been extended twice legislatively through March 31, 2020. This aspect of the 2012 method was a main focus of the Workgroup’s review.

Under its charter to evaluate the current methodology, the Workgroup examined various alternatives for distributing ICP funds. Each method was evaluated to determine whether the distribution complied with Federal requirements, optimized the entirety of the State’s Federal DSH allocation and other criteria as outlined below. The following report presents the findings of the Workgroup and does not reflect an endorsement of any of the proposals which this report describes.

II. Introduction

Indigent care funding helps ensure that hospitals can provide health care services to patients who are unable to pay for the cost of their care. While the percentage of uninsured New Yorkers has been reduced by half, from 10 percent in 2013 prior to implementation of the Affordable Care Act to 5 percent in 2017, there are still approximately 1.1 million New Yorkers who remain uninsured.

The method for distributing indigent care funds is based on statute and has varied over time. Initially, the methodology allocated funds based on the provision of “charity care” and “bad debt” incurred by hospitals regardless of patient type. However, over time and in response to provisions in the Affordable Care Act, the State’s methodology has transitioned to a formula based on the number of services a hospital provides to uninsured and Medicaid patients. The

current disbursement methodology went into effect in January 2013, has been extended by the Legislature twice, and is now due to expire on March 31, 2020. In anticipation, the 2019 enacted state budget established a workgroup to make policy recommendations regarding disproportionate share hospital and indigent care pool funding. The Workgroup was constituted in June 2018, and led by three co-chairs and comprised of an additional 19 members. The Workgroup met four times between June and November 2018 to review the current distribution method and identify alternative methods for consideration by state policymakers. In each meeting, Workgroup members discussed their perspective on ways to achieve the goals of the indigent care funding and on the current distribution methodology. The Department of Health (Department) and three of the organizations represented on the Workgroup ultimately presented alternative options for distribution methods.

This Report describes the Workgroup discussions, provide details about alternative distribution options suggested by Workgroup members and sets forth a series of recommended criteria by which policymakers should evaluate distribution options. The Report also discusses the potential impact of proposed regulatory actions at the federal level that, while outside the purview of this Workgroup, would have a significant impact on both the funding and need for indigent care.

The Department thanks the Workgroup co-chairs and members for their contributions to this important initiative, and for so generously sharing their time and expertise. The Department would also like to thank the interested stakeholders and other guests who attended the Workgroup meetings and provided valuable comments.

III. Workgroup Formation, Membership and Goals

The Indigent Care Pool (ICP) Workgroup was established pursuant to a joint agreement by the Executive and Legislature as part of the 2018-19 Enacted State Budget. The purpose of the Workgroup was to discuss potential changes to the methodology used to distribute \$795 million in indigent care pool funding annually. This commitment called for the Workgroup to be convened no later than June 1, 2018, with a report of its findings submitted to the Executive and Legislature by December 1, 2018.

The Workgroup was co-chaired by Elisabeth Benjamin, Vice-President of Health Initiatives, Community Service Society of New York; Bea Grause, President, Healthcare Association of New York State; and Dan Sheppard, Deputy Commissioner, Department of Health, Office of Primary Care and Health Systems Management. The Department publicly invited expressions of interest in Workgroup membership, and achieved a balanced panel of members, comprised of providers, labor representatives, health plans and consumer advocates from various geographic regions of the State, who were selected from a group of submitted nominees:

- Sudha Acharya South Asian Council for Social Services
- Anthony Andrews, Ed.D. NYC Health + Hospitals Community Advisory Board
- Leon Bell NYS Nurses Association
- Colleen Blye Montefiore Health System
- Claudia Calhoon The New York Immigration Coalition
- Sharon Chesna Mothers and Babies Perinatal Network of South Central NYS
- Moira Dolan AFSCME, AFL-CIO, DC 37
- Gary J Fitzgerald Iroquois Healthcare Alliance
- Amanda Gallipeau Empire Justice Center

- Michael Israel Westchester Medical Center
- Lara Kassel Medicaid Matters NY
- Mitchell Katz, M.D. NYC Health + Hospitals
- Phyllis Lantos New York Presbyterian Hospital
- Eric Linzer Health Plan Association
- Helen Schaub 1199 SEIU
- Rebecca Telzak Make The Road New York
- Hugh Thomas Rochester Regional Health
- Dennis Whalen Northwell Health
- Elisabeth Wynn Greater New York Hospital Association

IV. **Background Information**

Overview of Disproportionate Share Hospital Payments

Disproportionate Share Hospital (DSH) payments refer to a pool of Medicaid dollars made available to hospitals for uncompensated care to uninsured and Medicaid patients. The amount is capped by Section 1923(c) of the Federal Social Security Act and calculated on an annual Federal fiscal year (FFY) basis.

New York State distributes the full amount of their annual DSH allotment through four major programs: The Indigent Care Pool, the Indigent Care Adjustment (ICA), DSH Intergovernmental Transfers (IGTs), and DSH for Institutes for Mental Disease (IMDs) which is distributed by the Office of Mental Health (OMH). The breakout of the State’s annual DSH allotment for FFY 2018 is as follows:

Program	Gross Amount	Recipients
Indigent Care Pool (ICP)*	\$795	Public and Voluntary Hospitals
Indigent Care Adjustment (ICA)	\$412	Public Hospitals
Intergovernmental Transfers (IGT)	\$1,799	Public Hospitals
IMDs	\$605	OMH Operated Hospitals
Total	\$3,611	

**Excludes \$339M which has been paid out through the Voluntary Upper Payment Limit (UPL) but would need to be paid out via the ICP methodology if there is insufficient UPL room.*

In addition to the limit set by the Statewide DSH allotment, each hospital is subject to a facility-specific DSH cap. These facility-specific DSH caps, calculated annually through an audit process which includes both Medicaid and uninsured losses, reflect the maximum annual amount of gross DSH dollars a hospital can receive.

The non-federal share of ICP payments is included in the state’s Medicaid Global Spending Cap. It is funded by revenue from the Health Care Reform Act (HCRA), including revenue received from hospital assessments. This amount is matched with Federal dollars, subject to the limits described above, to generate gross annual ICP payments of \$795 million to New York hospitals. Consistent with the charge of the Workgroup, this Report focuses on distribution methodologies related to Indigent Care Pool funding.

Current ICP Distribution Methodology

The current ICP distribution methodology is the result of a 2012 ICP Workgroup process and became effective in January 2013. The calculation of each hospital's share of total ICP funding includes several steps. It begins by multiplying each hospital's uninsured units of service by the hospital's Medicaid reimbursement rates. This amount is then converted to cost utilizing a statewide cost adjustment factor. The result is then reduced by the payments the hospital received from uninsured patients to arrive at net adjusted uncompensated care costs. A nominal need scale based on hospital specific inpatient Medicaid volume as a percentage of total volume for all hospitals is applied to net adjusted uncompensated care costs to arrive at nominal payments which are then used to calculate the allocation percentage for each hospital. Allocation percentages are calculated separately for public and voluntary hospitals. These percentages are then applied to the total ICP public and voluntary pools amounts to determine the funding that each hospital will receive prior to the application of the "transition collar" as explained below.

The 2013-14 Enacted state budget included an additional transition pool payment of \$25 million annually to smooth funding swings resulting from the January 2013 implementation of the then new ICP methodology. The 2013 methodology also established a transition collar that sets a "floor" and a "ceiling" on the amount of ICP funding each hospital receives relative to that same hospital's average ICP payment during the three-year period January 2010 through December 2012. In short, if the January 2013 methodology resulted in a lesser distribution than the average during the three-year period, the loss of funding would be limited by a specified percentage, for example, 85 percent in 2018 and 82.5 percent in 2019. Conversely, if the January 2013 methodology yields an amount that is greater than the three-year average, the amount of the increase is subject to a ceiling percentage that is specific to the voluntary or public pool, whichever is relevant.¹

The amount of the transition collar fluctuates annually. In 2018, the total value of ICP funds allocated by the collar is \$159.5 million (including the \$25 million transition pool). As of the date of this Report, the 2019 "ceilings" have not been determined pending completion of cost report audits. It is important to note that hospitals receive no less than their "floor" and no more than their "ceiling" as a result of this transition collar.

The transition collar and pool payments (which have been included in both statutory extensions of the ICP methodology) help to ensure that hospital-specific funding changes because of the 2013 methodology occur gradually. This minimizes revenue reductions for all hospitals, including those that are financially distressed. However, the broad application of the collar to all hospitals has been criticized by some who argue that it extends the "bad debt" component of the methodology and, thereby, reduces ICP fund allocations to hospitals that have a higher proportion of uninsured units of service and Medicaid patients.

V. ICP Workgroup Meeting Dates and Topics

The Workgroup met four times between July and November 2018, twice in New York City and twice in Albany. Although the meetings were not subject to the Open Meetings Law, members of the public who requested to attend were welcome, and time was set aside at all meetings to

¹ For example, in 2018 the ceiling is 1.143 for distributions from the public pool and 1.330 for distributions from the voluntary pool.

allow for non-Workgroup members in attendance to make comments to expand the information and points of view available to the Workgroup. The meetings were held on July 11, September 12, October 10, and November 9, 2018.

At the July 11, 2018 meeting, the co-chairs presented the following guiding principles for discussion with the Workgroup and to frame upcoming discussions:

- The methodology to distribute ICP funds should be consistent with Federal requirements that incentivize states to target payments to hospitals which have high levels of Medicaid inpatients and high levels of uninsured patients and should not consider bad debt;
- ICP allocations should preserve separate funding streams for public and private hospitals as is reflected in the current distribution methodology; and
- Revisions to the ICP allocations methodology should be evaluated in conjunction with any negative impact of such changes on hospitals that have a high public payer mix, serve vulnerable populations, and are in significant financial distress.

An overview of the current DSH program and ICP distribution methodology was also presented with time for discussion and questions from the Workgroup.

On September 12, 2018, the Workgroup met for a second time and primarily focused its discussion on what some members indicated was the most controversial element of the current ICP distribution methodology, the “transition collar”. As explained above, this collar was incorporated into the current ICP distribution methodology to mitigate significant increases and decreases that certain hospitals would have experienced when the distribution methodology changed in 2013. The Department presented to the Workgroup the impact of removing the transition collar from the current distribution method. While the collar is cost neutral in aggregate, its removal, absent any other changes in method, would increase distributions to 78 hospitals by a total of \$160 million, with corresponding reductions in distributions to 97 hospitals. Of note, removal of the transition collar would adversely impact 46 of the 71 hospitals that meet the statutory definition of Enhanced Safety Net (ESN) hospital enacted as Section 3 of Part K of Chapter 57 of the Laws of 2018 (Appendix A) by \$88 million, collectively. The purpose of the presentation was not to support continuation of the collar, but rather to demonstrate the impact that its removal would have on hospitals which serve high numbers of uninsured and Medicaid patients.

The October 10, 2018 meeting began the Workgroup process for identifying and examining alternative distribution methodologies. The Department began the discussion by presenting variations of an alternative that would remove the transition collar and use the same formula to distribute funds based on uninsured units of care and Medicaid nominal scale as described in Section III above, but create a pool of \$200 million by reducing the Voluntary Indigent Care Pool from \$656 million per year to \$456 million and then distribute that pool to only those hospitals that meet the definition of Enhanced Safety Net hospital based on the following three alternative methodologies: 1) the current ICP methodology (Uninsured Units x Medicaid Rate x SWAF (Statewide Weighted Adjustment Factor (SWAF)) x Nominal Need); 2) the percentage of each ESN hospital’s DSH cap to the total DSH caps for all ESN hospitals; and 3) the percentage of each ESN hospital’s uninsured units to the total uninsured units for all ESN hospitals.

At the final meeting on November 9, 2018, all representatives were given the opportunity to present alternative distribution methodologies to the Workgroup. Alternatives were presented by HANYS, New York City Health and Hospitals (H+H) and NYSNA.

The HANYS proposal, prioritized its preference for continuation of the existing formula due to concerns related to the impending federal DSH cuts. The approach utilizes the existing transition collar to direct ICP funding to vulnerable hospitals, leaving intact the core elements of the current ICP formula as follows: 1) Where possible, utilize the construct of the current ICP formula, which is both ACA-compliant and CMS approved; 2) maintain the current public and non-public ICP pools at the same funding levels; 3) continue the current methodology for the public pool; and, 4) adjust the distribution methodology for the voluntary pool to target funding to hospitals that have a special designation and/or a higher uninsured, Medicaid and/or Medicare caseload. For these hospitals, the proposal would: a) eliminate the ceiling collar when it helps direct ICP dollars to them; and b) retain the current phase-down of the floor collar when it helps protect their ICP dollars.

NYC Health + Hospitals' proposal eliminates the transition collar and seeks to address the collateral negative financial impact on hospitals that are designated as ESN or in financial distress and provide services to vulnerable populations that are predominantly public pay by changing the ICP methodology and overall DSH fund allocations to leverage new federal Medicaid funds. Specifically, the H+H proposal utilizes the following elements: 1) Reduce the ICP pool by \$300 million and reallocate these funds for enhanced Medicaid rates targeted at public and voluntary Enhanced Safety Net and other financially distressed hospitals; 2) reallocate the \$25 million transition pool to Critical Access Hospitals (which are categorically designated as ESN) and financially distressed providers; and, 3) reallocate the \$150 million federal DSH allotment that is freed up by reducing the ICP pool by \$300 million to public hospitals where it can be matched by IGTs from their sponsoring municipal entities. The H+H proposal does not directly increase the state share of Medicaid spending, but does redistribute the state's overall DSH allotment between programs and recommends the use of some Essential Plan federal trust fund dollars to fill remaining gaps caused by the elimination of the transition collar to at-risk hospitals.

NYSNA presented a paper outlining a series of recommendations and endorsing the NYC H+H proposal. The NYSNA recommendations include: 1) Eliminate the transition collar; 2) increase the overall Medicaid reimbursement rates for ESN hospitals by 10%, preferably from outside of the DSH programs but potentially from within the ICP and other DSH programs if the rate increase could not be accommodated within the state's Medicaid Global cap; 3) change the priority order of the DSH program allocations to increase the predictability of how much overall DSH funds H+H will receive in a given year; 4) create funding tiers within the ICP allocation for voluntary and non-major public hospitals to prioritize distribution to ESN hospitals and hospitals with higher uncompensated Medicaid and uninsured costs; 5) change the ICP formulas for the statewide cost adjustment factor and nominal need scale (including incorporating outpatient utilization) to further benefit hospitals with the higher rates of Medicaid and uninsured patients; and, 6) standardize hospital policies and procedures for application of the Hospital Financial Assistance Law.

VI. Workgroup Discussions

Criteria for Evaluating Alternative Distribution Methods

Following the presentation of each of these alternatives at the November 9th meeting, Workgroup members were asked to offer their point of view on the factors or characteristics that could be used to determine what an effective distribution model should accomplish. The purpose of this discussion was to engage the Workgroup in an open dialogue to identify key priorities. By the end of the discussion, the Workgroup had identified a set of suggestions that could be used to evaluate the various distribution options, as summarized below. The Workgroup did not explicitly attempt to apply these evaluation criteria to the proposals presented to the Workgroup. Rather, the evaluation criteria presented a valuable framework for future consideration of any statutory changes to the ICP Pool methodology.

Several suggestions for evaluation criteria had near consensus within the Workgroup. Among them, Workgroup members strongly suggested that the evaluation criteria consider whether the distribution method complies with federal requirements, thereby mitigating the risk to the state's health care system in the event of federal cuts to DSH allocations as anticipated under the Affordable Care Act. Similarly, several Workgroup members stated that the distribution method should optimize the availability of the state's DSH allocation so that critically needed funding is not "left on the table". At several points during the discussion, Workgroup members expressed that the distribution method should not have "unintended consequences". However, workgroup members could not agree on what would specifically constitute an "unintended consequence". In the end, it appeared there was consensus that changes to the methodology should produce a fiscal result that is consistent with the purpose of DSH funding, but the State should also seek to address any adverse impacts on financially vulnerable hospitals caused by such changes. Some Workgroup members agreed that these impacts could be addressed within a revised ICP methodology. Other Workgroup members felt that ICP funding should only be targeted to hospitals with high Medicaid and uninsured patients, that other sources of State funding should be used to offset impacts to other financially vulnerable hospitals.

Workgroup members also suggested, but did not necessarily agree on, other characteristics by which the distribution methods could be evaluated including whether the distribution method:

- Rewards hospitals that serve disproportionately high volumes of uninsured patients;
- Does not financially destabilize essential safety net hospitals, financially distressed hospitals critical access hospitals and sole community hospitals;
- Has a mechanism that limits increases and decreases to hospital specific dollar allocations that would otherwise result from a calculation that considers only uninsured units of service and Medicaid losses;
- Would result in significant immediate (not gradual) and unpredictable shifts in funding between facilities;
- Includes a component for bad debt which was viewed by some workgroup members as contrary to federal rules or intent governing the allocation of DSH funds;

- Uses in its calculation both inpatient and outpatient services consistent with the DSRIP goal of reducing avoidable inpatient hospital stays;
- Supports and encourages hospitals to provide hospital financial assistance to eligible patients;
- Helps ensure continued access to certain to essential services such as inpatient mental health services; and,
- Impacts the longer view of hospital stability in the State.

Some Workgroup members also emphasized the importance of ensuring compliance with New York's Hospital Financial Assistance Law (HFAL) which, in relevant part, limits what hospitals can charge patients with limited incomes and no health insurance. It was also raised during Workgroup discussions that, in accordance with the law, hospitals are audited on an annual basis for substantial compliance with HFAL. While this audit process was recognized, some Workgroup members suggested that there were opportunities to improve these audits.

The ICP Exists in a Far Larger and Challenging Environment

At several points in Workgroup discussions, members observed that ICP funding levels and distribution methods under discussion do not live in isolation but rather in a larger environment of health care policy at a time of significant uncertainty at the federal level.

Workgroup members cited two looming changes at the federal level as factors that could significantly impact indigent care funding. The first relates to a planned reduction in federal DSH funding, which was originally enacted as part of the federal Affordable Care Act in 2010 based on the expectation that as more people became insured, the need for DSH funding would decline. These reductions are scheduled to go into effect in the Federal Fiscal Year which begins on October 1, 2019. While the exact impact of these reductions is not known at this time, some estimates conclude that New York's funding could be reduced by up to \$1.3 billion in the first year and up to \$2.6 billion in each year thereafter.

The second significant policy issue raised was a proposed rule issued on October 10, 2018 by the Department of Homeland Security that would expand an immigration policy known as "public charge" to include receipt of community Medicaid for the first time. Under this proposed rule, some non-citizens applying for lawful permanent residence status would face adverse immigration consequences if they were found to have used Medicaid benefits even though they were entitled to Medicaid eligibility under federal law. Although not yet promulgated, Workgroup members observed the "chilling" effect this proposed rule is already having on non-citizens applying for or renewing Medicaid coverage. This could translate into an increase in the number of uninsured New Yorkers placing more demand on indigent care funding.

VII. Conclusion

The Workgroup brought together a diverse group of experts representing hospitals, labor representatives, health plans and consumers to engage in a thoughtful and at times lively discussion of the importance of indigent care funding to New York's health care delivery system the patients it serves. Workgroup members offered varying points of view on the metrics that

should be used to distribute the funding and the characteristics of the hospitals that should receive the funding, or the majority of the funding, as well as the impact of underlying Medicaid and Medicare reimbursement levels.

Given the diverse viewpoints, the Workgroup did not reach consensus on an exact distribution methodology. However, several themes emerged from the discussions. Most notably that, in making decisions about indigent care funding allocations, policymakers must be cognizant of potential changes in federal policy that are expected to adversely impact New York, and that first and foremost distribution methods must consider the interest of patients and their access to health care services, and safeguard the hospitals that care for these patients regardless of whether the hospital is an urban or rural area of the State.

Section 3 of Part K of Chapter 57 of the Laws of 2018

§ 3. Section 2807-c of the public health law is amended by adding a new subdivision 34 to read as follows:

34. Enhanced safety net hospital program.

(a) For the purposes of this subdivision, "enhanced safety net hospital" shall mean a hospital which:

(i) in any of the previous three calendar years, has met the following criteria:

(A) not less than fifty percent of the patients it treats receive Medicaid or are medically uninsured;

(B) not less than forty percent of its inpatient discharges are covered by Medicaid;

(C) twenty-five percent or less of its discharged patients are commercially insured;

(D) not less than three percent of the patients it provides services to are attributed to the care of uninsured patients; and

(E) provides care to uninsured patients in its emergency room, hospital-based clinics and community-based clinics, including the provision of important community services, such as dental care and prenatal care;

(ii) is a public hospital operated by a county, municipality, public benefit corporation or the state university of New York;

(iii) is federally designated as a critical access hospital; or

(iv) is federally designated as a sole community hospital.

(b) Within amounts appropriated, the commissioner shall adjust medical assistance rates to enhanced safety net hospitals for the purposes of supporting critically needed health care services and to ensure the continued maintenance and operation of such hospitals.

(c) Payments made pursuant to this subdivision may be added to rates of payment or made as aggregate payments to eligible general hospitals.