Redesigning
THE MEDICAID PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH

Medicaid Redesign Team (MRT)

Payment Reform and Quality Measurement Work Group

FINAL RECOMMENDATIONS

Medicaid Redesign Team
Payment Reform & Quality Measurement Work Group
Final Recommendations – November 1, 2011

Work Group Charge: The Work Group will develop a series of payment reform and quality measurement recommendations to facilitate the transformation of our health care system. To the extent practicable the Work Group will seek consistency with the reform imperatives of the MRT Phase 1 work, as well as the Patient Protection and Affordable Care Act (ACA).

Federal health reform is commencing with a focus on the development of shared savings models, pioneer accountable care organizations, risk-sharing assumption demonstrations, clinical integration, and bundling of services and payment across traditional silos of delivery. Inherent in all of these emerging initiatives is a patient-centric focus on quality improvement and patient safety.

In the context of the above, focused activities for the Payment Reform & Quality Measurement Work Group includes:

- ✓ *Recommend how New York State can encourage the development of innovative payment and delivery models. These may include: Accountable Care Organizations, Bundling, Gain Sharing, Clinical Integration, and other shared savings and/or risk-sharing arrangements.*
- ✓ *Explore and identify evidence-based quality indicators to benchmark New York's Medicaid program and the provider delivery system. Performance goals will also be developed to inform future Medicaid policy.*
- ✓ *Explore issues in the New York State Disproportionate Share Program and related indigent care funding mechanisms, including compliance with federal law and Health and Human Services/Centers for Medicare and Medicaid Services (HHS/CMS) requirements; consider recommendations for needed work to ensure long-term viability.*
- ✓ *Consider criteria that can be used to identify "safety net" providers, and the implications of such a designation on local planning, financing, care delivery, and oversight.*
- ✓ *Should time permit, the Work Group may also assess the implications of the product of other MRT Work Groups on: payment for workforce education, including graduate medical education; workforce shortages; IT investment; and opportunities for access to capital financing.*[1]

[1] The Work Group decided not to pursue these additional topics in order to devote their limited time to the discussion and development of recommendations for their focused activities. Given other opportunities, the Work Group will revisit these additional issues.

WORK GROUP MEMBERSHIP:

- **CO-CHAIR: Dan Sisto,** President, Healthcare Association of NYS
- **CO-CHAIR: William Streck, MD**, Chair, New York State Public Health and Health Planning Council
- **Rick Abrams**, Executive Vice President, Medical Society of the State of NY
- **Elisabeth R. Benjamin**, Vice President of Health Initiatives, Community Service Society
- **Scott Cooper, MD**, President and CEO, St. Barnabas in the Bronx
- **Michael W. Cropp, MD**, President and CEO, Independent Health
- **Joanne Cunningham**, President, Home Care Association of NYS
- **Emma DeVito**, President and CEO, Village Care of New York
- **Paloma Izquierdo-Hernandez, MS, MPH**, President & CEO, Urban Health Plan
- **Sneha Jacob, M.D. M.S.,** Assistant Professor of Clinical Medicine, Columbia University, Assistant Medical Director, New York Presbyterian System Select Health
- **James R. Knickman**, President and CEO, NYS Health Foundation
- **Ronda Kotelchuck**, Executive Director, Primary Care Development Corporation
- **Phyllis Lantos**, Executive Vice President and CFO, New York Presbyterian Hospital
- **Art Levin**, Director, Center for Medical Consumers
- **Joseph McDonald**, President and CEO, Catholic Health Services of Western NY
- **Joseph Quagliata**, President and CEO, South Nassau Communities Hospital
- **Steven M. Safyer, MD**, President and CEO, Montefiore Medical Center
- **Susan Stuard**, Executive Director, Taconic Health Information Network and Community
- **James R. Tallon, Jr.**, President, United Hospital Fund
- **Pat Wang**, President and CEO, Healthfirst
- **Marlene Zurack**, Senior Vice President, Finance, NYC Health and Hospitals Corporation

MEETING DATES AND FOCUS:

- ✓ **September 20:** The Work Group met for the first time in Troy, New York. The Work Group was provided with an overview of the MRT's progress thus far and informed of the timeframe for completion of the Work Group's objectives. The Work Group reviewed and agreed upon its charge. The Work Group then discussed and developed guiding principles, providing staff with a working draft of guiding principles that would be revised and presented at the next meeting. The Work Group agreed that flexibility was an important component to the development of any recommendations. The Chairs then provided a presentation on federal budget challenges (i.e., federal payment reductions, ACA's impact on Medicare management, impact of federal deficit reduction/debt ceiling, Select Committee reduction options, and Medicare Recovery Audit Contractor) and innovative payment models (i.e., the role of the CMMI, available federal demonstration projects, CMS shared savings models, and New York MRT reform options). The Work Group discussed at length the expenditures and unique needs of New York's dual eligible population (i.e., persons eligible for Medicare and Medicaid). In addition, the Work Group spent some time discussing quality measures, with a particular emphasis on the distinction between science-based versus standard of care. The Work Group also reviewed data on Medicaid patients that meet the federal definition for qualifying for health homes and sources of HCRA funding. The Work Group requested additional information from the Department of Health on health homes and DSH/Indigent Care funding.

- ✓ **September 27:** The Work Group met for the second time in Troy, New York. The Department of Health provided further information on health homes and DSH/Indigent Care funding as requested at the September 20 meeting. The Work Group discussed the draft health home payments for sample populations and the role of potentially preventable admissions (PPA) and potentially preventable readmissions (PPR). The Department of Health presented on essential community providers. The Work Group requested additional information from the Department of Health on how the various federal demonstrations and MRT program proposals presented at the first meeting would work together to improve patient care in New York's health care system. The Work Group then reviewed and commented on the proposed guiding principles, providing staff with additional revisions for incorporation and presentation at the next Work Group meeting. The Work Group also reviewed and commented on the first three proposed recommendations, providing staff with revisions for incorporation and presentation at the next Work Group meeting.

- ✓ **October 18:** The Work Group met for the third time in New York City. The Department of Health presented on how the Department of Health sees the federal demonstration projects and MRT program proposals working together to improve patient care in New York's health care system. After the presentation, the Work Group reviewed and adopted the proposed guiding principles. The Work Group then began to review and revise the four proposed recommendations. All four proposed recommendations were adopted by the Work Group.

Outside Experts Consulted with: No outside experts were consulted or presented at the Work Group meetings; however, the Work Group was provided with comments and suggestions submitted by stakeholders and the public to the Payment Reform & Quality Measurement Work Group email address. To date, the Work Group has received approximately 25 submissions through its website.

Brief Summary of Discussions that Led to Focus on Recommendations Included in this Report: It was particularly important to the Work Group that the concept of patient-focused and patient-centered care be the driving force behind any payment reform and quality measurement recommendations. The Work Group took its responsibility to Medicaid beneficiaries/patients very seriously and tried to ensure that any recommendation they set forth would improve the New York State health care system while improving the overall health outcomes of its patients. To this end, the Work Group felt it was important to establish a set of guiding principles to consider when developing recommendations. The guiding principles adopted by the Work Group are as follows:

- ✓ ***Innovative payment models should:***

1) Be transparent and fair, increase access to high quality health care services in the appropriate setting, and create opportunities for both payers and providers to share savings generated if agreed upon benchmarks are achieved.

2) Reduce fragmentation of health care services and promote fully integrated patient centered/directed models where possible.

3) Be accountable for patient outcomes and improved health of the population being served.

4) Be scalable and flexible to allow providers in all settings and communities (regardless of size) to participate, reinforce health system planning, and preserve an efficient essential community provider network.

5) Allow for flexible multi-year phase-in to recognize administrative complexities, including network development and systems requirements (i.e., IT).

6) Align payment policy with quality goals.

7) Reward improved performance as well as continued high performance.

8) Incorporate strong evaluation component and technical assistance to assure successful implementation.

✓ ***Quality measures should:***

1) Be transparent and fair, be based on a standard of care or evidenced based science, and be cognizant of or align with nationally accepted measures.
2) Include metrics to measure health outcomes of the population being served.
3) Be flexible enough to recognize advances in medicine that will improve patient care.
4) Include patient experience/satisfaction, access to care, and social/economic measurements where applicable.
5) Seek to align quality measurement across payers including Medicare and others.
6) Be appropriately risk-adjusted, including socio/economic and cultural competence metrics, especially when used to compare providers or make incentive payments.
7) Align with appropriate payment models and incentivize providers across the continuum of care.
8) Promote patient participation and responsibility in health care decision-making.
9) Incorporate strong evaluation component and technical assistance to assure successful implementation.
10) Include a public reporting process on measures and outcomes.

The Work Group also recognized that the New York State health care system is on the verge of a major reconfiguration. Governor Andrew Cuomo's call to have virtually all Medicaid recipients enrolled in some form of care management, as well as the immediate need to bend the New York State Medicaid cost curve, was duly noted. The Work Group discussed reform opportunities at both the federal and state level, with a particular emphasis on the ability of such reform opportunities to work cohesively to align payment methodologies, improve the provision of health care services in New York State, and increase patient satisfaction.

SUMMARY LISTING OF RECOMMENDATIONS:

1) **Pursue partnership agreement with CMS to integrate Medicaid & Medicare service delivery and financing for the dual eligible population.**

GOALS:

- ✓ Achieve "*triple aim*" as defined by CMS: Improve patient care experience; improve the health of populations; and reduce the per capita cost of health care.
- ✓ Create opportunities for providers/payors/patients to realize financial benefits and improved outcomes as system efficiencies are achieved and quality benchmarks attained.
- ✓ Promote improved patient care.
- ✓ Secure investment of resources from CMS which are required to implement this recommendation. Such funds need to be flexible and could be used for continued funding of care management (Health Homes) beyond the two year incentive period; HIT; ACO or Medical Home development; shared savings initiatives; other innovative initiative development; and transition of all patients into care management with a focus on patient-centered/patient-focused approaches.

2) **Adopt a series of accepted performance measures across all sectors of health, aligning measures already being collected in New York in Medicaid managed care, including managed long term care with federal requirements.**

GOALS:

- ✓ Need to utilize a core set of measures that are flexible to address the evolving delivery systems and tailored to the setting and population served.
- ✓ Be based on a standard of care or evidence-based science.
- ✓ Implement public reporting process on measures and outcomes.
- ✓ Reward providers for improved and/or continued high performance.
- ✓ Take into consideration differences in clinical conditions as well as social conditions in measuring outcomes when the data is available.

3) **Develop general principles that can be applied towards revising the New York State DSH/Indigent Care program.**

GOALS:

- ✓ Develop a new allocation methodology consistent with CMS guidelines to ensure that New York State does not take more than its share of the nationwide reduction.
- ✓ Fair and equitable approach to allocate funds across hospitals with a greater proportion of funds allocated to those hospitals that provide services to un/underinsured.
- ✓ Simplify allocation methodology and consolidate pools.

4) Create financing mechanisms that strengthen the financial viability of New York's essential community provider network.

GOALS:

- ✓ Ensure patient access to provider services that may be otherwise jeopardized by the provider's payer mix or geographic location.
- ✓ Focus should be on essential providers that are not financially viable, provide a disproportionate level of care to financially vulnerable populations, provide essential health care services, and provide a high fraction of health services in their market area.
- ✓ Provide supplemental financial support to ensure the long-term viability of designated providers.
- ✓ Reinvest a portion of savings generated from reforms and downsizing within an impacted community to maintain that community's health care delivery system.
- ✓ Implement review process for designated providers for administrative/operational efficiencies, quality standards, provision of essential services, and potential for integration or collaboration with other entities.

At the October 19 meeting, the Work Group approved each of the above recommendations by a vast majority. The concerns of those few who dissented are articulated in this report or in white papers and presentations included as attachments to this report.

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Recommendation Number: 1

Recommendation Short Name: Pursue partnership agreement with CMS to integrate Medicaid & Medicare service delivery and financing for the dual eligible population.

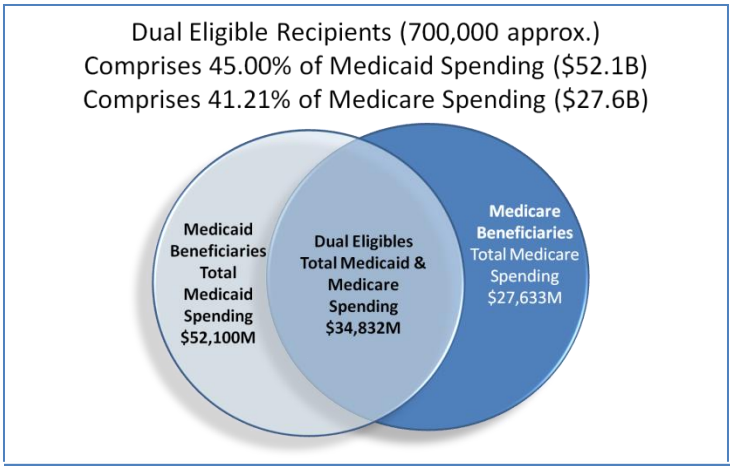
Program Area: CMS Waiver

Implementation Complexity: High

Implementation Timeline: The Department of Health needs to begin discussions with CMS immediately in order to ensure that timeframes for achieving full integration of the Medicaid and Medicare programs can be achieved within 3-5 years.

Required Approvals: ☑ **Administrative Action** ☐ **Statutory Change** ☐ **State Plan Amendment** ☑ **Federal Waiver**

Proposal Description: There are approximately 700,000 individuals in New York State that are eligible because of their age or disability for coverage under both the Medicare and Medicaid programs. The expense to care for this population is enormous: DOH estimates that within New York State this population consumes approximately 45% of Medicaid ($23.4B) and approximately 41% of Medicare ($11.3B) spending.[2] New York recognizes that there is an opportunity to optimize care and reduce costs for this population by restructuring the system in which they receive care.



Sources: Medicare – National health expenditure data (2004) trended by Medicare market basket to 2010; Medicaid – United Hospital Fund (2010) data net administration costs; Duals – Kaiser (2005) data trended by market basket to 2010 & Kaiser (2007) dual eligibles share percentage (45%) applied to 2010 Medicaid spending estimate. Note: DOH is in the process o working with CMS to update data.

[2] It should be noted that DOH is working with CMS to review these New York State estimates. Nationally, the dual eligible population in 2008 consumed $250 billion – 1/4 of Medicare spending and nearly 1/2 of Medicaid pending.

Governor Andrew Cuomo, through the work of the MRT, has set as a goal that virtually every member of the Medicaid program be enrolled in some kind of care management organization within the next 3-5 years. New York sees full capitation as its preferred financial arrangement, but is open to other financing systems in the interim. The Department of Health recognizes that reaching full capitation where acute, behavioral health and long-term care services are all coordinated by a single accountable entity will take years to develop.

New York has spent considerable time developing managed long term care plans that integrate Medicare and Medicaid. New York's enrollment in Programs of All-Inclusive Care for the Elderly (PACE) is the highest in the nation and the Medicaid Advantage Plus (MAP) program was one of the first in the nation to integrate care through a managed care plan that participates in both Medicare and Medicaid. Nevertheless, each of these models has limitations and enrollment has grown slowly.

Under this recommendation, New York would seek a waiver from CMS that would redefine the relationship between the two largest public health care programs by taking on risk for the delivery and financing of Medicare services for dual eligibles in New York. In turn, New York would partner through "sub-capitation arrangements" with health plans and/or integrated provider groups (ACOs) that have sufficient network capacity and are capable of delivering care and assuming risk for the full spectrum of Medicare and Medicaid covered services.

It will be important to work with health plans and providers in considering inclusion of risk adjustment and other measures into capitation or sub-capitation arrangements.

The dual-integration initiative will be a key component of a CMS waiver. New York will seek to secure an investment of federal resources. New York is optimistic it can secure waiver approval because such investments will generate additional returns and the Federal government will realize significant savings from Phase 1 of New York's Medicaid redesign plan ($18.8 billion over 5 years).

Financial Impact: This proposal will coordinate the care of approximately 700,000 dual eligible beneficiaries who spend a combined total of almost $34.8 billion in Medicaid and Medicare per year. There is the potential to generate significant savings through the improved management of this population and alignment of billing practices.

Health Disparities Impact: Dual eligibles are more than twice as likely to be members of racial and ethnic minorities (42% compared to 16% of non-dually eligible Medicare beneficiaries). They are more than four times as likely to have a cognitive or mental impairment as non-dually eligible Medicare beneficiaries and 60% have a limitation in at least one activity of daily living.[3]

Integrating Medicare and Medicaid services will allow for program design features that recognize the unique demographics and needs of New York's dual eligible population.

[3] Source: National Academy for State Health Policy; Making Medicaid Work; Issue Brief #6; December 2004.

Benefits of Recommendation: This proposal creates a potential WIN-WIN-WIN.

- ✓ *Members win because they will have access to better coordinated health care services.*
- ✓ *The Federal government wins because it has generated savings.*
- ✓ *New York State providers/health plans win because of simplified administration and the opportunity to share in savings that result from care integration.*

By locking in on a guaranteed funding stream, New York can work with the provider/plan community to manage resources and may mitigate the impact of additional federal Medicare cuts beyond those currently programmed through sequestration.

- ✓ *Waiver funds could be used for the implementation/development of Health Homes, Accountable Care Organizations, Patient Centered Medical Homes, Clinical Integration, Shared Savings, and/or Gainsharing.*

The current system is complex. Patients and providers are forced to navigate a variety of plan and program types. There are inconsistent rules and processes that confuse and frustrate patients and providers alike. These complexities and inconsistencies deter participation by providers and decrease patient satisfaction. A single integrated entity will reduce administrative burdens on providers and patients, resulting in a better overall experience for providers and patients.

Most importantly, a single integrated entity will improve patient outcomes through effective care management. The dual eligible population has a high utilization rate of health care services. Establishing a single entity to oversee the care of these patients will ensure that these patients receive the right care at the right time and in the right setting.

Concerns with Recommendation: If the New York State health care system does not perform and generate savings under the capitation payment, it could put New York at financial risk for any losses.

- ✓ *It is clear that for this effort to be successful, New York will need a strong partnership with the provider community to work together (to truly bend the cost curve). Through care management and proper financial incentives the reward should far outweigh the risk.*
- ✓ *Moreover, the Department of Health will develop a risk sharing process and phase-in whereby the State will only accept Medicare capitation payments for members in those regions of the State where adequate plan capacity exists. Careful implementation will significantly curb risk for both the State and plans/providers.*

Key to the success of their efforts, the State and CMS need to develop option(s) that allow for the full integration of Medicaid and Medicare programs – both financially and programmatically – while preserving members' freedom of choice. Furthermore, the State needs to work aggressively with CMS to remove current barriers to the growth in existing programs such as PACE and Medicaid Advantage Plus, add integrated programs for custodial nursing home residents, and develop criteria for potentially new area coordination entities, as appropriate.

There was some discussion regarding the speed, process and design of the waiver initiative New York State is pursuing in order to achieve full integration of the dual eligible population. Specific concerns raised related to the state going at risk for such a large and needy population in light of the State's current fiscal status and its capability to simultaneously assume responsibility for Medicare risk.

Work Group members also expressed concern that as operational efficiencies are achieved through improved health care systems there is the potential that savings will leave the health care system: Funding could exit the State to the extent for-profit commercial plans withdraw funds from the system. To address this concern, the Department of Health will continue to work with plans and other stakeholders to develop shared savings or other models (e.g., bundled payments, gainsharing, etc.) that will measure system efficiency (e.g., reduce ED use, avoidable hospital admissions, etc.) at the community level and reinvest these savings equitably among accountable entities.

Impacted Stakeholders: Medicare and Medicaid beneficiaries; health care providers who care for Medicare and Medicaid beneficiaries; health insurance companies who provide services to Medicare and Medicaid beneficiaries; not-for-profit organizations that currently assist persons eligible to receive Medicare and Medicaid benefits apply for and navigate the Medicare and Medicaid programs.

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Recommendation Number: 2

Recommendation Short Name: Quality Measurement

Program Area: Quality

Implementation Complexity: Mid to High

Implementation Timeline: Continue to collect quality data on Medicaid managed care and Managed long term care (MLTC); begin measurement of Health Home populations in 2012-2013; begin measurement of mental health/substance abuse in 2012; begin measurement of long term care (outside of MLTC) in 2012; expand measurement of mental health/substance abuse in 2013-2014; expand measurement of long term care in 2013-2014.

Required Approvals: ☑ **Administrative Action** ☐ **Statutory Change** ☐ **State Plan Amendment** ☐ **Federal Waiver**

Proposal Description: Adopt a series of accepted performance measures across all sectors of health care, aligning measures already being collected in New York in Medicaid managed care (including managed long term care (MLTC) with federal requirements**.** To the extent that quality measures are used as incentives or penalties in reimbursement, they should be aligned across the managed care and fee-for-service systems to the extent feasible (e.g., preventable admissions).

Governor Cuomo and the MRT have set a goal to not only reduce the cost trend of the Medicaid program, but to also improve quality. New York State has a long history of measuring, monitoring, and improving quality for enrollees in Medicaid managed care through a system called the Quality Assurance Reporting Requirements (QARR). Reported annually, QARR is a set of performance measures for Medicaid, Child Health Plus, and commercial managed care. While significant progress has been made in the quality of care delivered to Medicaid managed care enrollees, currently there isn't a measurement system to monitor the quality of care provided in fee-for-service Medicaid.

Under this recommendation, New York will build off of its experience in quality measurement and monitoring in Medicaid managed care by developing systems to measure the care in Medicaid fee-for-service, specifically in the areas of mental health/substance abuse and long term care. In addition, efficiency metrics including avoidable hospitalizations, avoidable emergency room visits, potentially preventable readmissions, and potentially preventable complications will be measured across various entities including managed care, health home, and patient-centered medical homes.

Key to this redesign effort will be an examination of patient utilization of hospital services, especially patient flow through emergency departments in relation to access and quality of service. This may require discussions with CMS regarding current federal requirements.

To accomplish this recommendation, the following goals will need to be met:

- ✓ *Need to utilize a core set of measures that are flexible to address the evolving delivery systems.*
- ✓ *Be based on a standard of care or evidence-based science.*
- ✓ *Implement public reporting process on measures and outcomes.*
- ✓ *Reward providers for improved and/or continued high performance.*
- ✓ *Take into consideration differences in clinical conditions as well as social conditions in measuring outcomes when the data is available.*

Financial Impact: None

Health Disparities Impact: Quality measurement will have a positive impact on minorities in the Medicaid program in New York. Building off the work done with Medicaid managed care plans using QARR data, quality measures can be shown by race/ethnicity; this is already being done today for Medicaid managed care and is available on the Department of Health website. Stratification of all quality measures by race/ethnicity will be a requirement.

Benefits of Recommendation: Quality measurement across all of Medicaid ensures accountability for process and outcomes. Quality measurement is also the starting point of the quality improvement cycle: Plan, Do, Study, Act. Without measurement, there cannot be improvement.

Concerns with Recommendation: Some sectors of the Medicaid program will be accountable for quality outcomes for the first time. There is an initial reluctance to measurement due to uncertainty of the results, but the commitment to measurement and improvement will continue to be the long term goal.

Impacted Stakeholders: Managed care plans; health homes; providers; consumers.

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Recommendation Number: 3

Recommendation Short Name: Indigent Care Funding Program

Program Area: Indigent Care

Implementation Complexity: High

Implementation Timeline: Short-Term

Required Approvals: ☐ Administrative Action ☑ Statutory Change ☑ State Plan Amendment ☐ Federal Waiver

Proposal Description: First, the Medicaid Redesign Team Payment Reform & Quality Measurement Work Group recommends that general principles be developed that will be used to guide the task of reforming the New York State Indigent Care Program. These principles will be applied once the federal Centers for Medicare and Medicaid Services (CMS) provides guidance for determining how state allocations of federal Disproportionate Share Hospital (DSH) funding will be reduced as part of the implementation of the Affordable Care Act. This new federal law requires the reduction of current available federal funding for DSH to pay for care of the newly insured.

The goals for changes to the State's Indigent Care Program are as follows:

1) *Develop a new allocation methodology (consistent with CMS guidelines) to ensure that New York does not take more than its share in the nationwide reduction.*
2) *Develop a fair and equitable approach to allocate funds across hospitals with a greater proportion of funds allocated to those hospitals that provide services to the uninsured, underinsured and Medicaid populations.*
3) *Simplify the current funding allocation methodology.*
4) *Protect access to care for the targeted population as federal health care reform is implemented.*
5) *Promote transparency and accountability.*
6) *Develop stronger link between compliance with the Hospital Financial Assistance Law and receipt of payments from the Indigent Care Program that is not more onerous for providers and restrictive for patients.*

The Workgroup has developed a set of guiding principles that should be utilized in the reform of the current Indigent Care Program which are as follows:

1) *It is critical for all New York State health interests to advocate against further reductions in federal funding for DSH and other programs for eligible consumers and providers.*
2) *The Indigent Care Program needs to be transparent and accountable.*
3) *New York State should make changes in its uncompensated care pool allocation formulas consistent with CMS guidelines in order to preserve its share of available federal DSH funding and to maintain current funding levels to the extent possible.*
4) *Uncompensated care pool allocations should preserve separate funding streams for public and private hospitals as is reflected in the current methodology.*
5) *Subject to federal guidelines, the components of need in valuing uncompensated care support should be primarily based on charity care and uncompensated care to low-income uninsured, underinsured, and Medicaid patients, but not bad debt.*
6) *New York State should distribute funds across hospitals using an allocation methodology that distributes a greater proportion of funds to those hospitals providing a disproportionate share of uncompensated care need. Proper weighting should be given such that the priority is first targeted to the uncompensated care provided to the uninsured and the underinsured, and then to the Medicaid population.*
7) *New York State should explore and pursue with the federal government all available options, including but not limited to a waiver, to preserve public hospital essential community provider funding and mitigate shortfalls caused by reductions in federal DSH funding.*

The Indigent Care Program needs to be transparent and accountable. The work group heard serious concerns about variability and compliance with the Hospital Financial Assistance Law. To address these issues of transparency, accountability, and compliance the work group further recommends that a new work group be convened – including DOH representation for input and guidance on administrative, legal and federal share concerns – to:

- Recommend strengthened means to ensure compliance with the Hospital Financial Assistance Law; and
- Consider appropriate links between the Indigent care Program distribution methodologies and Hospital Financial Assistance law.

Financial Impact: None at this time, however, it is projected that New York allotment of federal DHS funding will be reduced by $71 million in federal fiscal year 2013/2014 and increasing to $85 million in federal fiscal year 2014/2015. It is projected that total funding to New York will be reduced by over $2.5 billion through federal fiscal year 2019/2020.

Health Disparities Impact: New York needs to ensure that federal DSH funding is distributed in accordance with federal requirements to ensure that access to services for the uninsured, underinsured and Medicaid population is not negatively impacted.

Benefits of Recommendation: Hospitals will be appropriately reimbursed for providing services to the targeted population and access to these services will not be negatively impacted.

Pool distributions will be dependent upon compliance with the Hospital Financial Assistance Law.

Concerns with Recommendation: Implementation of changes to the funding formulas for DSH in accordance with CMS guidelines may create the potential for a significant reallocation of funding to hospitals. This, in turn, could result in unintended fiscal consequences that may need to be addressed through a waiver or other means.

Impacted Stakeholders: Hospitals; consumers.

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Recommendation Number: 4

Recommendation Short Name: Establish two initiatives – Essential Community Provider Network & Vital Access Providers

Program Area: Payment Reform

Implementation Complexity: Medium

Implementation Timeline: Resources for this initiative will need to be available very soon in order to facilitate the Brooklyn reconfiguration plan and meet other community needs.

Required Approvals: ☑ **Administrative Action** ☐ **Statutory Change**

☑ **State Plan Amendment** ☑ **Federal Waiver (Possible)**

Proposal Description: The health care system in New York State is undergoing a significant transformation. The Affordable Care Act (which will be implemented in large measure starting in 2014) will significantly decrease the number of uninsured New Yorkers, but these gains come with potentially deep cuts in Indigent Care funding to hospitals and other programs. Moreover, to close the federal budget gap, the Congressional Deficit Reduction Committee is contemplating deep reductions in Graduate Medical Education that will put tremendous pressure on the State's teaching hospitals. And, lastly, the Medicaid Global Cap will limit Medicaid spending to the inflation rate which will further compress growth. These measures, taken in total, could have the unintended consequences of destabilizing health care providers that serve a high proportion of the uninsured, Medicaid, and other vulnerable populations.

The Payment Reform & Quality Measurement Work Group spent considerable time discussing the health care environment and the impact rapid changes will have on providers who serve disproportionate numbers of uninsured, Medicaid, Medicare, and other vulnerable populations. While the Payment Reform & Quality Measurement Work Group recognizes that change is inevitable, it strongly believes that safety-net providers who offer essential services within their communities must emerge from this restructuring stronger financially than they are today.

To this end, the Payment Reform & Quality Measurement Work Group recommends two initiatives – Essential Community Provider Network (short-term funding) and Vital Access Providers (ongoing rate enhancement or other support) - to ensure access to care for patients. The Work Group recommends that New York State assume an active role in ensuring certain essential community providers (hospitals, nursing homes, D&TCs or home health providers) be eligible to receive short-term funding to achieve defined operational goals such as a facility closure, merger, integration or reconfiguration of services. After collaborating with the members of the Medicaid Redesign Team Health Systems Redesign: Brooklyn Work Group, this measure has the potential to be a useful tool and could be used in concert with HEAL/FSHRP funding in the reconfiguration and rightsizing of the Brooklyn health care system and be consistent with previously endorsed Medicaid Redesign Team recommendations (i.e., MRT #67: Assist Preservation of Essential Safety-Net Hospitals, Nursing Homes and D&TCs).

The Work Group members shared the view that if the State is going to offer certain providers an enhanced Medicaid rate then it needs to be offered in very limited situations to accomplish specific well-defined goals.

In order to receive funding under this initiative, providers must apply to the Department of Health for consideration and present a plan with clearly defined benchmarks for achieving well-articulated goals, including improved quality, efficiency, and the alignment of health care resources with community health needs. This plan will also include a budget that will be the basis for reimbursement and for identifying required financial resources. Failure to meet goals articulated in the plan within the defined timelines (no more than 2-3 years) will result in the immediate termination of the rate enhancement.

Moreover, based on the understanding that the Department of Health has with CMS, it is incumbent upon the facility to also demonstrate how its plan and the investment will ultimately return savings longer term for the Medicaid program.

For this initiative to be successful and not drive significant new expenditures to the Medicaid program, it should be used strategically and sparingly. The Commissioner of Health (with community input) will make the final decision concerning which facilities are eligible by applying the following criteria:

- ✓ *Demonstration of integration of services with other providers and improved quality, access, and efficiency;*
- ✓ *Engagement with community stakeholders and responsiveness of plan to community health needs;*
- ✓ *Financial viability based upon certain metrics (profitability, debt load, and liquidity);*
- ✓ *Provision of care to financially and medically vulnerable populations;*
- ✓ *Provision of essential health services; and/or*
- ✓ *Provision of an otherwise unmet health care need (e.g., behavioral health services).*

Benchmarks that must be present in any acceptable plan are key to the success of this initiative. Such measures might include:

- ✓ *Administrative and operational efficiencies;*
- ✓ *Quality and population health standards;*
- ✓ *Provision of essential services;*
- ✓ *Improved integration or collaboration with other entities; and/or*
- ✓ *Achieving health care cost savings.*

Furthermore, for the Department of Health to make the required investment of taxpayer funds for this purpose, it must have confidence in the applicant's governance structure and the ability of its board and executive leadership to implement the plan and take decisive steps to stabilize the financial condition of the facility, while improving quality and efficiency. As a requirement to receive these funds, it is also possible restructuring officers and new board members (with expertise in certain areas) could be recruited to replace or enhance the existing leadership as a means to ensure the plan's fruition.

Vital Access Provider (VAP):

The Work Group also envisioned the need to provide ongoing rate enhancement or other support to a small group of hospitals, nursing homes, D&TCs, and home care providers, as described above, but under more stringent basis over a longer term. These facilities will still be required to submit a plan and a budget for meeting defined goals, which would include approaches to advance community care, but the purpose of these funds is to provide longer term operational support. Examples of providers that could receive this designation and enhancement could include efficient hospitals and other providers in rural communities that have already reconfigured services to create integrated systems of care and that require a rate enhancement to remain financially viable and continue to provide a service not offered elsewhere in the community (e.g., emergency department, trauma care, obstetrics). Moreover, in urban areas, qualifying providers will be unique in that they serve a very high proportion of Medicaid and financially vulnerable populations, provide unique services that are not offered by other providers within the community, and have serious financial problems. Again, the VAP provider designation and any allocation of funds are subject to approval by the Commissioner of Health and is pursuant to a dynamic plan to better the health of the community. These facilities would also be required to demonstrate satisfaction of benchmarks specified by the Commissioner.

The Work group encourages the state to support the development of physician practices in underserved areas and the involvement of physician practices in integrated systems of care, particularly through electronic health records and payment arrangements. We acknowledge that steps have already been taken in this regard through enhanced Medicaid payments for physician practices that have received patient-centered medical home accreditation and Doctors Across New York practice support and loan repayment assistance grants. The expansion of Medicaid managed care has also driven additional physician participation in the Medicaid program and promoted primary care for Medicaid beneficiaries. Nevertheless, more can be done to support physicians seeking to practice in underserved areas.

Financial Impact: This recommendation will need to be funded through a combination of State allocations and up to $450 million in HEAL/FSHRP funds. State allocations could be generated through the redirection of Transition 1 and/or 2 funds and the New York State General Fund. In addition, the State could also seek a federal Medicaid waiver from CMS to acquire funding specifically designated for VAP.

Benefits of Recommendation: This recommendation will ensure continued access to vital health care services for the uninsured, Medicaid, and other vulnerable populations during a period in which the health care system is experiencing significant restructuring and payment reform. VAP funds coupled with HEAL/FSHRP reserves of up to $450 million provide a sufficient funding source to ensure the smooth transition of services within communities and to provide reinvestment capital for new investment paradigms.

The temporary rate enhancement and the VAP program are expected to improve accountability and transparency while addressing community health needs. Requiring providers to submit plans for how funds will be utilized to achieve specific restructuring goals that meet the community's health care needs will ensure that funds are being used appropriately. To this end, the Work Group recommended that plan, progress reports, and funding allocations be kept current and made available on the Department of Health's website.

Concerns with Recommendation: The Payment Reform & Quality Measurement Work Group voiced serious concerns that within the Medicaid Global Cap VAP funding would be used to support/prop-up financially inefficient and ineffective facilities. Furthermore, the Payment Reform & Quality Measurement Work Group worried that parochial interests would drive the inappropriate use of VAP funding and undermine the intent of the program by extending timelines or bending eligibility requirements. Moreover, under the Medicaid Global Cap (where Medicaid spending is fixed to an annual appropriation), there was concern that unwise use of these funds could ultimately impact other providers if spending exceeds the cap and broader based cost containment actions are required.

- ✓ *Accordingly, for reasons explained above, this program will need to be used sparingly to achieve specific strategic goals with public reporting on progress.*

Impacted Stakeholders: Health care providers who deliver a significant portion of services to the uninsured, Medicaid, and other vulnerable populations; health care consumers in under-served communities.

REPORT ATTACHMENTS

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A New Proposal for Charity Care in New York State

This proposal contains three major recommendations:

Funds from the Charity Care hospital pool would be distributed to hospitals to provide services for the uninsured. 100% of the funding would be allocated to all hospitals on the basis of actually providing care to uninsured patients. By accomplishing this important new allocation method, hospitals would receive payment to meet their obligation of providing care for the uninsured under the Patient Financial Assistance Law (Manny's Law).

A special Upper Payment Limit (UPL) payment would be developed for safety net hospitals, which are defined as hospitals that provide a significant level of their services – 50% -- to Medicaid and uninsured patients.

The Diagnostic and Treatment Center pool would be increased to a level that would match the percent of coverage of payment for services to the uninsured that is provided to the hospitals from their Charity Care pool.

Background

Each year nearly $1 billion dollars is distributed from a hospital Charity Care pool. This is one of the least accountable, least transparent distributions of public funding. Since 1983, New York State has done the right thing in collecting dollars and distributing the dollars to hospitals but this is done under the guise of providing funding for the care of the uninsured and the under-insured. The problem is the method of distribution of the funding. Hospitals have been allowed to use an antiquated accounting methodology to compute how much they are owed from the pool.

In 2008, the State Health Department set up a Task Force to review the pools and ultimately recommend that 100% of the funding be distributed to hospitals based on the care that they provide to uninsured patients. This makes a great deal of sense, particularly in light of the passage of the Patient Financial Assistance Law (Manny's Law) which requires all hospitals to develop and publicize a Charity Care policy for uninsured patients with low

incomes. With this legal requirement, hospitals should be paid for providing uncompensated care for free or on a sliding fee scale.

There are strong, well-funded efforts by hospital associations and their allies to maintain the current unaccountable system. They claim that many hospitals would be hurt if funds that they get, without earning them, were taken from private hospitals, it would hurt many hospitals. This lobbying effort has been very successful with both houses of the state legislature.

The Proposal

There are safety net hospitals in low-income, medically underserved, immigrant and communities of color that provide many services for Medicaid patients and some uninsured patients. A system should be developed for recognizing the service of these hospitals. We would recommend that the State develop a special Upper Payment Limit (UPL) payment for safety net hospitals that can prove that they provide a significant percent of services to Medicaid and uninsured patients. The special UPL payment would only be available for Safety Net hospitals which will be defined based on services to Medicaid and uninsured. This Medicaid rate could include dollars for providing services for low-income patients and proving that they are efficient. There should also be a limit set on the size of the salaries and compensation packages at $1 million for the hospital executives and some other staff. If hospitals spend more on salaries for this staff, the overage should be disallowed in any computation of hospital costs for calculating Medicaid reimbursement.

By developing this special rate, the Charity Care dollars could be freed up and used for their primary purpose – paying for care for the uninsured. One hundred percent of the Charity Care pool dollars should be distributed to hospitals based on their accurate reporting of the numbers of uninsured patients to whom they provide services – emergency, clinic, and inpatient care. The hospitals would have to fully, and appropriately, document that the patient was interviewed for, and approved for, financial assistance. All hospitals, including the public hospitals, would be eligible for full reimbursement for providing this care. (Note: in New York City, the public hospitals provide 66% of all hospital-based clinic care for the uninsured). If private hospitals resist the redistribution of charity care dollars based on providing care for the uninsured, a mechanism must be developed to develop a way of referring uninsured patients to these hospitals, such that they actually provide enough services for the uninsured to earn the charity care dollars they receive.

A third component of this modest proposal is an increase in the charity care pool dollars for Diagnostic and Treatment Centers. These facilities, many of them public or FQHC's, also treat large number of uninsured patients. Dollars in this pool should be increased so that the clinics receive the same percentage of funding for caring for uninsured patients as hospitals do from the pool. D&TC's already have a transparent, accountable method of reporting and dollars are distributed from this pool strictly on the basis of providing care for the uninsured.

Revised: January 14th, 2011

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The Commission on the Public's Health System is firmly committed to equal access to quality health services for everyone regardless of race, ethnicity, language spoken, diagnosis or the ability to pay. The recommendations that we make are based on that commitment.

*We support the proposals put forward by the Center for Disability Rights and the New York Association on Independent Living, that would reduce New York State spending and promote the independence and integration of seniors and people with disabilities.

*We support the recommendations of the Community Health Care Association of New York State and the Primary Care Coalition to expand access to primary health care services. We know that comprehensive, quality, community-based primary care will reduce the cost of care and improve health status – the number of avoidable hospitalizations will decrease.

*We support the Principles of Medicaid Matters New York.

In addition, we believe that:

- There is enough funding in the Medicaid budget, if spent well, so that savings can be made and access to health care, eligibility, and benefits be maintained. It should be embarrassing to all of us that New York State ranks 50th (dead last) with the highest percent of Ambulatory Care Sensitive hospitalizations. With an expansion of primary care services that works for everyone – including expansion of hours, guarantee of continuity and comprehensiveness – New York could change this ranking and save dollars in the Medicaid budget.

- There needs to be full transparency and accountability in the spending of any and all public funds. The charity care pools must become transparent and dollars should be used to pay for services that are rendered to uninsured patients, and patients that are underinsured for particular services. Our more detailed proposals on Charity Care are included.

- New York State must use any and all federal dollars wisely. A recent, not yet approved, Medicaid waiver extension to CMS requested $300 million over a period of three years to move towards medical home status and improved primary care training programs in teaching hospitals. CPHS has been coordinating an effort to negotiate with the State Health Department to ensure, if the waiver is granted, that there are clear standards within the waiver agreement, monitoring and enforcement of these standards.

- Limits must be set on pricing/costs of personnel and other than personnel costs that are included in calculating the Medicaid reimbursement rate for each facility. There must be a maximum in salary and benefits for any given employee at a facility that will be included in the calculation of Medicaid rates. We would propose that the maximum dollar amount would be $1 million, but would preferably be set at $500,000.

- There are health care facilities that are located in low-income, medically underserved, immigrant and communities of color that are needed for the services that they provide. Some of the facilities, and other larger institutions, are not cost-effective because of inefficiencies. The State Department of Health, has and must use, the ability and capacity to manage the finances of these facilities so that they can be viable and remain in operation. The estimates of 40% of patients disappearing from care when their hospital is closed, is unacceptable.

A review of the Berger Commission recommendations give additional proposals for the State to pursue, which for the most part it has not done.

- **Under reimbursement and Medicaid** – "Reimbursement reform should strengthen the long-term viability of institutions that disproportionately serve vulnerable populations including the uninsured and low income patients."
  "Reimbursement reform should encourage the provision of preventive, primary and other baseline services and discourage the medical arms race for duplicative provision of high-end services."
  "Future capital investments should reflect shifts in the venue of care from institutional to home and community based settings."
  "Expand the availability of home and community-based alternatives to nursing home placement and educate physicians, paraprofessionals, and consumers about these alternatives."

- **Under developing primary care infrastructure** – "ensuring that all New York residents have a primary care 'home'."
  "Stemming the erosion of primary care capacity."
  "Ensuring adequate financial support to the primary health care safety net."

January 19, 2011

Proposal (Short Title): Equity for the Uninsured and Safety-Net Providers

Theme: Charity Care for the Uninsured and Medicaid Payment Increases for Safety-Net Providers

Proposal Description:

Distribution of charity care funding will be made transparent and used to pay for the care of the uninsured. New federal law under Health Reform redirects some of the current federal funding under DSH (Disproportionate Share Hospitals) to pay for care of the newly insured. Remaining DSH funding will be distributed to states based on three factors: the remaining number of uninsured; whether the state uses the DSH money to pay for care of the uninsured; and whether the state targets DSH funding to hospitals with high Medicaid patients. To continue getting funding, New York is required to change the current way that the federal funding for charity care is distributed to hospitals.

Background:

New York has a long history of using public financing to help hospitals provide care to uninsured and underinsured patients. The State remains committed to supporting those institutions that provide this care. If you examine the way in which that money has been allocated, however, some inconsistencies arise. The formulas that allocate bad debt and charity care funds are complex and opaque. It is not clear how the allocation of money connects back to actual care provided to actual patients. The Commission on the Public's Health System (CPHS), and others, has long advocated for a more transparent system, where money indeed follows the patient.

Over a period of years, the CPHS documented the allocation of public dollars from the State's $847 million Hospital Indigent Care Pool intended to compensate hospitals for the indigent care they provided. As a result of this effort, CPHS published two reports that showed little or no relationship between the actual dollars received by the hospitals from the hospital Charity Care pool and the amount of health care services they provided to the uninsured. It is interesting to note that there is a separate community health center pool to pay for the care of the uninsured. This pool of dollars is much smaller than the hospital pool and is funding allocated to health centers based on their reporting care that they provide to the uninsured.

Despite recent efforts to change the allocation of charity care dollars, provider resistance has maintained the system almost untouched. There has, however, been movement over the last several years to ensure that they uninsured have access to health services regardless of their ability to pay. The first change was passage of the Hospital Financial Assistance Law (Subdivision 9-a of Section 2807-k of the New York

State Public Health Law) – also called Manny's Law. For the first time, the State requires that all hospitals develop a charity care sliding scale fee policy for New York residents with incomes at or below 300% of the federal poverty level, post these policies, and notify patients of their right to a sliding fee scale for payments based on income and family size.

The second important change came as the result of a 2008 State Task Force which reviewed the hospital charity care system, and resulted in the requirement that 10% of the total $847 million in the hospital Charity Care pool be distributed on the strength of the hospital showing it had cared for numbers of uninsured patients. The benefit of this very small movement is that in order to receive a share of the 10%, hospitals have to report all of the care they delivered to people with no health insurance. The reporting has enabled a more in-depth look at what hospitals are doing to provide care and to match that care to the dollars being distributed to these institutions.

Proposal:

Two Principles should guide the distribution of charity care funds: (1) Funding should follow the patient – hospitals should be paid from the charity care pool for providing care to uninsured patients; and (2) Payments to hospitals should be progressively increased based on providing a larger proportion of care for the uninsured.

Based on these principles, CPHS and an Advisory Committee worked with a consultant to developed specific changes in the way the State distributes Charity Care funding:

- The first step was to start with a uniform reimbursement, the median statewide Medicaid reimbursement rate, as a leveler for all hospitals in the state.
- The second step was to add to this median rate the regional costs for things like salaries and then to add more for the care of sicker patients.
- The third step is to add more dollars on a progressive scale for hospitals that treat a higher percentage of uninsured patients.
- The final step only occurs if the federal DSH dollars are greatly reduced; we proposed a way of combining the current pools to fund public and private hospitals. This is very important because the 21 public hospitals in the state provide the lions' share of services for the uninsured.

In a separate proposal, CPHS addresses additional funding for safety-net hospitals that provide a high proportion of care for Medicaid patients but do not provide as much care for the uninsured. To ensure that these hospitals do not lose money as a result of the charity care recommendations, we propose a special increase in the Medicaid reimbursement rate to cover potential funding shortfall. We also propose an increase in

the dollar amount of the Charity Care pool which funds community health centers for the care of the uninsured. This pool is much smaller than the hospital pool, even though health centers report the number of uninsured patients/visits and get paid for the care of the uninsured. The Health Centers/D&TC's provide services for large number of uninsured patients.

Financial Considerations

The Hospital Indigent Care (Charity Care) Pool has $847 million annually for distribution to hospitals. Redistribution will also serve as a powerful incentive for hospitals providing care for the uninsured are paid for providing this care. This is also a way for encouraging hospitals to meet their obligations under Manny's Law, including posting information and informing patients of a sliding fee scale for uninsured patients with family income under 300% of the federal poverty level. Although this is currently a legal requirement, it is not at all clear how many hospitals are actually informing patients about charity care at the time that they arrive for services. If hospitals are motivated to inform patients about available charity care prior to hospitalizations for emergencies, more of the charity care funding would be used for preventive and primary care, which could lead to a reduction in expensive Emergency Room visits and a reduction in overall costs.

Another very important consideration is that in the not too distant future there will be a reduction in federal Disproportionate Share Hospital dollars to pay for newly insured patients under the Affordable Care Act (ACA). Federal DSH dollars will be reduced by $500 million in 2014. Allotment of the remaining dollars will be governed by regulations from the HHS Secretary.

"The methodology will be structured to ensure that states using DSH funding appropriately are able to retain such funding. Specifically, the methodology will:

*apply the largest reductions to states that (i) have the lowest uninsured rates (based on Census data), (ii) have the lowest levels of uncompensated care (excluding bad debts), and (iii) do not target DSH payments to hospitals with high volumes of Medicaid inpatient care..."[1]

If New York State does not make changes in the hospital charity care distribution formula this year, the state stands to lose millions of federal dollars.

Submitted by: Commission on the Public's Health System (CPHS). www.cphsnyc.org

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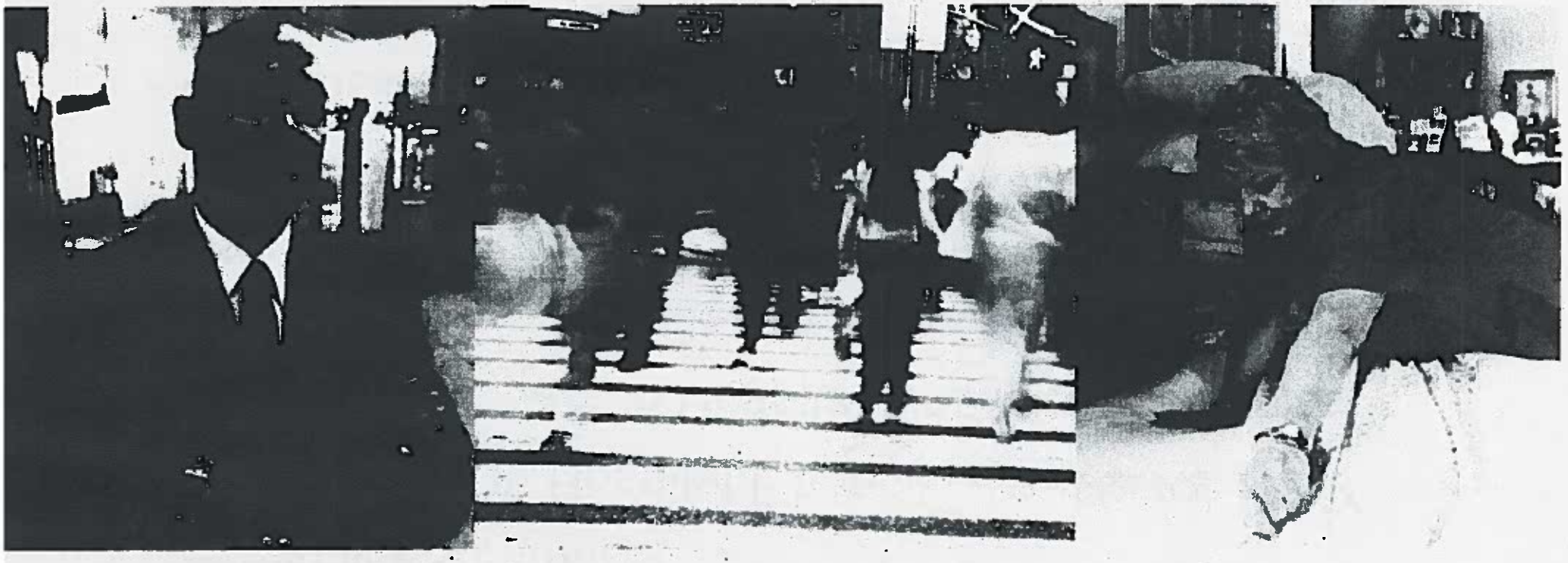
[1] *Implementing Federal Health Care Reform: A Roadmap for New York State.* Boozang, Patricia, Dutton, Melinda, Lam, Alice and Bachrach, Deborah. August 2010. New York State Health Foundation.

Removing Obstacles to Patient Financial Assistance in New York



September 26, 2011

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Community Service Society | Fighting Poverty Strengthening New York

DRAFT – 09/26/11

Outline of Presentation

- Executive Summary
- Background on Hospital Financial Assistance in NY
- Front-end Barriers to Hospital Financial Assistance
- Back-end issues Related to Hospital Financial Assistance
- Impending Funding Issues
- Conclusions & Recommendations

Executive Summary: CSS identifies problems with NY's uncompensated care system

- CSS analysis of SDOH data reveals that:
  - Hospitals do not comply with the Hospital Financial Assistance Law, but still get $1.1 billion in State Indigent Care Pool (ICP) funds.
  - ICP funds distributed are not tied directly to individual patients.
  - Hospital reporting practices are unaccountable and opaque.
- These practices put NY at risk of losing millions of dollars in federal DSH funds come 2014.

Executive Summary: Recommendations

- **The State should enforce and improve the Hospital Financial Assistance Law**
  - SDOH should perform statewide audits & enforcement annually.
  - Hospitals that fail to comply with HFAL should not receive any ICP funds.
  - To ensure consistency and fairness, the State should adopt and disseminate widely one uniform state-wide application used for financial assistance.
- **The State should directly tie the ICP funds to individual financial aid patients**
  - Hospitals should be incentivized to provide financial assistance. Hospitals should be required to process all uninsured and self-pay patients for financial assistance.
- **The State should develop a transparent ICP distribution methodology**
  - Adopt a 100% units of service methodology for distributing ICP funds.
  - Prioritize patients certified funder HFAL.
  - Any leftover funds can be used to reimburse for bad debt using a sliding scale.

Background on Hospital Financial Assistance in NY

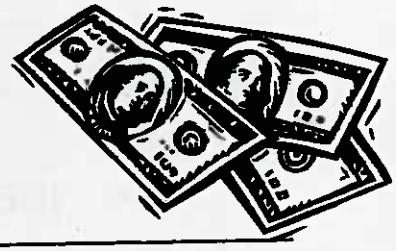
Background: What is the current status of New York's hospital financial aid system?

- Depressed job market and increasing number of uninsured results in more demand for uncompensated care at New York hospitals.
  - Under EMTALA, hospitals may not turn away emergency patients, but they bill a patient regardless of his or her ability to pay.
- The federal and NYS governments provide hospitals over $1 billion in Medicaid funds per year to cover uncompensated care costs.
- But, these funds are not directly tied to individual uninsured patients.
  - Hospitals send individual patients to collections, but are inconsistently reimbursed for costs they claim are associated with uncompensated care and bad debt.
  - Compliance with new financial aid law is patently flawed.
- Come 2014, under the ACA, there will be fewer uncompensated care dollars and those dollars will have much stricter rules.

Background: New York's Indigent Care Pool

- Since 1983, NYS has provided funds to hospitals to help cover uncompensated care and bad debts costs.
- Today, NY's "Indigent Care Pool" (ICP) is funded by federal Disproportionate Share Hospital (DSH) funds paid for by Medicaid (State match comes from various sources of revenue, including HCRA and hospital assessments).
- Uncompensated care in ICP is categorized in two ways:
  - Bad debts: unpaid medical bills from insured and uninsured patients that are considered to be uncollectable.
  - Charity care: financial assistance (free or reduced-cost care) given to low-income, uninsured patients considered to be "indigent" or "medically indigent."

How are patients supposed to get financial assistance?



- From 2003 to 2005, advocates complained that hospitals were not providing financial aid and engaged in overly harsh collection practices, but still received funds from ICP.
  - Extensive media coverage on the issue.
- In response, in 2006, the Hospital Financial Assistance Law (HFAL) enacted.
  - Requires all hospitals to have financial aid policies and applications to qualify for ICP funds.
- But ICP is still allocated under old rules that are unrelated to individual patient care of the new HFAL.

What the harm if patients do not get financial assistance?

- All patients who receive care at a hospital will receive a bill for that care. If they cannot pay it, many go into collections.
  - Medical debts and illness account for 62% of all personal bankruptcies in the United States (E. Warren et al, Am. J. of Med. 2009).
- Hospitals are allowed to place liens on primary residences as part of the hospital collection process.
  - 23% of all home foreclosures in the United States are caused by unmanageable medical bills (C. Robertson et al, Health Matrix, 2008).
- Fear of compounding medical bills can deter many patients from seeking necessary medical care until its too late. This leads to:
  - Worse health outcomes, even death.
  - Higher medical costs due to having to treat a worsened condition.
  - Higher medical bills for the patient.

Front-end Barriers to Hospital Financial Assistance

Junko M. experiences how one hospital violates the HFAL

Junko is a single mom from Japan with a young daughter. Both are uninsured. In early 2011, Junko's daughter received emergency medical care at New York Downtown Hospital. Afterwards, Junko was left with a bill that she could not afford. She tried to call the number for hospital financial assistance listed on her bill, but could not get through.

Frustrated, Junko sought out help from Make the Road New York. Junko's case handler found out that the phone number for financial assistance that was listed on the bill was incorrect. After getting the correct contact information, she was told that in order to apply for financial assistance, Junko needed to provide a social security card or US passport, and copies of bank statements, mortgage payments and utility bills.

Knowing that this information was not required by the Hospital Financial Assistance Law, the case handler asked the hospital representative to send her a copy of the hospital's financial assistance application. She was told that no such application exists, and that Junko just needed to bring the documents to their office.

Barriers to patient financial assistance

- Hospital financial assistance policies can be hard to find.
  - Hospitals supposed to publicly post financial aid info, but not all do.
  - SDOH website does not include copies of hospital policies.
- Consistent with the requirements of HFAL and SDOH rules, Hospitals allowed to design unique applications, procedure, and outreach strategy. But these applications and policies often:
  - Are often inconsistent with HFAL rule
  - Some hospitals have added impermissible barriers, like:
    - copies of bank statements or tax returns
    - social security cards or U.S. passports
    - credit card numbers
    - utility bills, or mortgage payments
    - proof of a Medicaid denial

CSS's survey of hospital financial aid policies: Access to information

What CSS did: CSS formally asked each New York hospital for a copy of its financial aid application and policy to help health consumers who seek health help through Community Health Advocates (CHA).

✓Follow up requests were made to non-responders.

What CSS found:

- 161 (81%) hospitals and hospital systems provided us with their policy summary and/or application or posted the information on their website.
- 37 (19%) did not provide CSS the information requested or did not respond.
  - ✓ After CSS sent a follow-up letter to HANYS with the results of our survey, 18 additional hospitals agreed to provide us with their policies.
- 6 (3%) provided their policy summary and/or application, but asked CSS not to post them on CHA website.

CSS's review of hospital financial aid policies: Application issues

- CSS evaluated each application and policy to determine if it met 5 basic HFAL requirements:
  - Explanation of income level eligibility (PHL § 2807-k-9-a (c))
  - Information on geographic service area (PHL § 2807-k-9-a (c))
  - Explanation of how to apply (PHL § 2807-k-9-a (c))
  - Instruction to ignore bills while application is pending (PHL § 2807-k-9-a (c))
  - Hospital contact information for financial assistance (PHL § 2807-k-9-a (a); SDOH guidance dated 5/11/09)

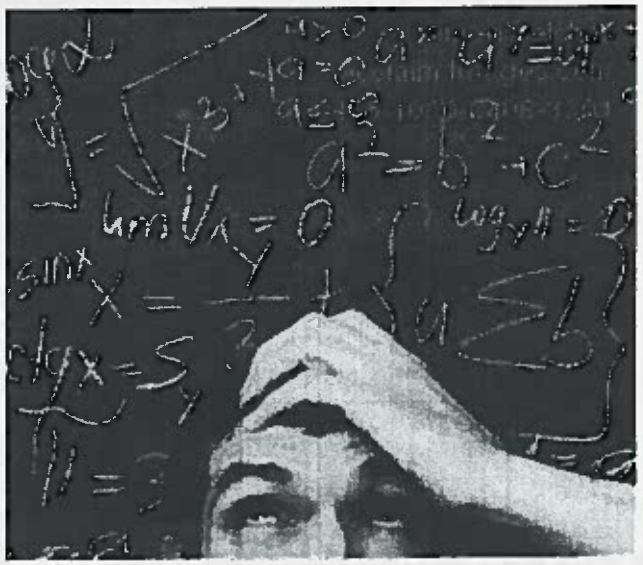
- CSS determined whether the policy:
  - Was available in languages other than English (PHL § 2807-k-9-a (e));
  - Included illegal barriers (asked patients for tax returns, monthly bill information, or a Medicaid denial) (PHL § 2807-k-9-a (e); PHL § 2807-k-9-a (a); SDOH guidance dated 5/11/09))

CSS's finds widespread violations of the HFAL

What we found:

- 70 percent (112) of hospitals who had provided us with application materials failed to meet the 5 basic legal requirements under the HFAL.
- 24 percent (39) hospitals who provided us with application materials have financial assistance applications that have additional, unlawful, barriers, such as demands for: tax returns, monthly bill information, or a Medicaid denial before application.
- 76 percent (122) of hospitals fail to provide financial assistance information in languages other than English.

Back-end Issues Related to Hospital Financial Assistance



Current SDOH reporting requirements for hospitals to get ICP funds

- To qualify for Indigent Care Pool funds, a hospital must:
  - Submit an annual institutional cost report (ICR)
  - Incur uncompensated care costs, or "targeted need," greater than ½ of 1% (.50%) of the hospital's total inpatient and outpatient costs
  - Provide an annual independent CPA certification that the hospital's billing, collection and account write-off procedures are consistent with the law and regulations
  - Comply with the requirements established by the hospital financial assistance law

Current SDOH reporting requirements on hospital financial assistance law

HFAL requires hospitals to report aggregate data to the SDOH, including:

- Hospital costs incurred and uncollected amounts due to providing services to patients with and without insurance, and those eligible for financial aid.
- The number of patients (by zip code) who applied for financial aid and how many were approved, denied, pending, or deemed incomplete.
- Reimbursement received from the Indigent Care Pool.
- The number of liens placed on primary residences through the hospital collection process.

The provision of financial assistance to patients under HFAL is unrelated to the costs listed on hospital ICP reports (prior page).

Key metrics: How hospitals measure losses for the purpose of getting indigent care pool funds

Bad debt/charity care (BDCC) – [Existing methodology]

- 90% of indigent care pool funds are distributed based on hospitals' reported losses due to bad debts and charity care for insured and uninsured patients.
  - Hospitals use unique accounting methodologies to determine bad debts and charity care, which can have different results.
  - These currently are reported in aggregate based on hospital charges.
  - The SDOI reduces each hospital's reported charges down to cost using a converter formula.
- Under the BDCC methodology, uncompensated costs include:
  - Insured patients who did not pay their co-pays or deductibles, or whose insurance only partially covers a service provided.
  - Self-pay patients who have insurance but it does not cover a service provided at all.
  - Uninsured patients (who have no form of health insurance coverage).

Key metrics: How hospitals measure losses for purposes of getting indigent care pool funds

Units of service

- 10% is distributed based on hospitals' reported losses measured using units of service to uninsured patients.
  - These are calculated by multiplying the number of inpatient and outpatient units of service provided to uninsured patients by the applicable Medicaid reimbursement rate, less any payments made by the patients.
  - Hospital losses reported are also due to bad debts and charity care.
- Under the units of service methodology, uncompensated costs include:
  - Self-pay patients who have insurance but it does not cover a service provided at all.
  - Uninsured patients (who have no form of health insurance coverage).

Distribution methodologies = many moving parts

- The indigent care pool is made up of several smaller sub-pools for major public hospitals, voluntary hospitals, minor public hospitals, high need voluntary hospitals, rural hospitals, and other targeted funding to hospitals who partake in graduate medical education.
- For the most part, each pool has its own methodology for distribution of funds. For example:
  - Major voluntary hospitals, the allocation is based on its share of total reimbursable costs relative to total reimbursable costs for all major hospitals.
  - These hospitals receive a greater distribution amount based on a sliding scale which provides more funds for hospitals with a higher targeted need (ratio of uncompensated care relative to total patient volume).
- Hospitals are generally reimbursed for only a portion of their reported uncompensated care costs.

Current Indigent Care Methodology and Funding

$1,182.5M in Total Funds

$395.2 Based on Uninsured Allocations*, $787.3 based on "Other" Allocations

** $310.5M of the $395.2M is targeted to specific groups of hospitals*

$765M: PHL 2807-k

- Major Public Distribution: **$139.3M**
  ($125.4M distribution based on 1996 allocation; $13.9M based on uninsured units x MA rates)
- Voluntary High Need: **$32.4M**
  (Distribution based on BDCC targeted need > 4% of costs)
- Voluntary Distribution: **$593.3M**
  ($530.7M distribution on BDCC targeted need; $62.6M on uninsured units x MA rates)

$82M: PHL 2807-w

- Rural Hospitals Distributions: **$32.3M**
  ($126K grants + BDCC based upon bed size and need statistic)
- Supplemental Voluntary High Need: **$32.4M**
  (Distribution based on BDCC targeted need > 4% of costs)
- Supplemental Voluntary Distribution: **$17.3M**
  ($9.1M distribution on BDCC targeted need; $8.2M on uninsured units x MA rates)

$335.5M: PHL 2807-k (5-b)

- Voluntary Teaching Regional Distributions: **$269.5M**
  (Based on 2007 unmet need - uninsured units x MA rate less hospital share of $847M allocation)
- Voluntary High MA Safety Net: **$25M**
  (Uncompensated care based on uninsured units x MA rates)
- Voluntary High MA Safety Net: **$25M**
  (Net MA losses from reform/DRP)
- Non-Teaching Hospitals: **$16M**
  (Uncompensated care based on uninsured units x MA rates)

Source: SDOH, New York Medicaid Redesign Payment Reform & Quality Measurement Work Group, September 20, 2011

DRAFT – 09/26/11

CSS's analysis of hospital ICR data: Hospital financial aid policies vs. financial aid distributed

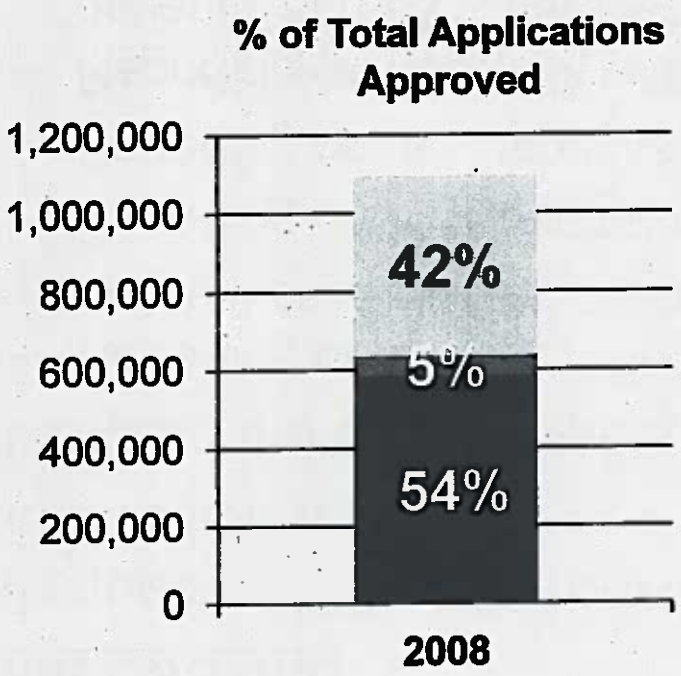
What CSS did:

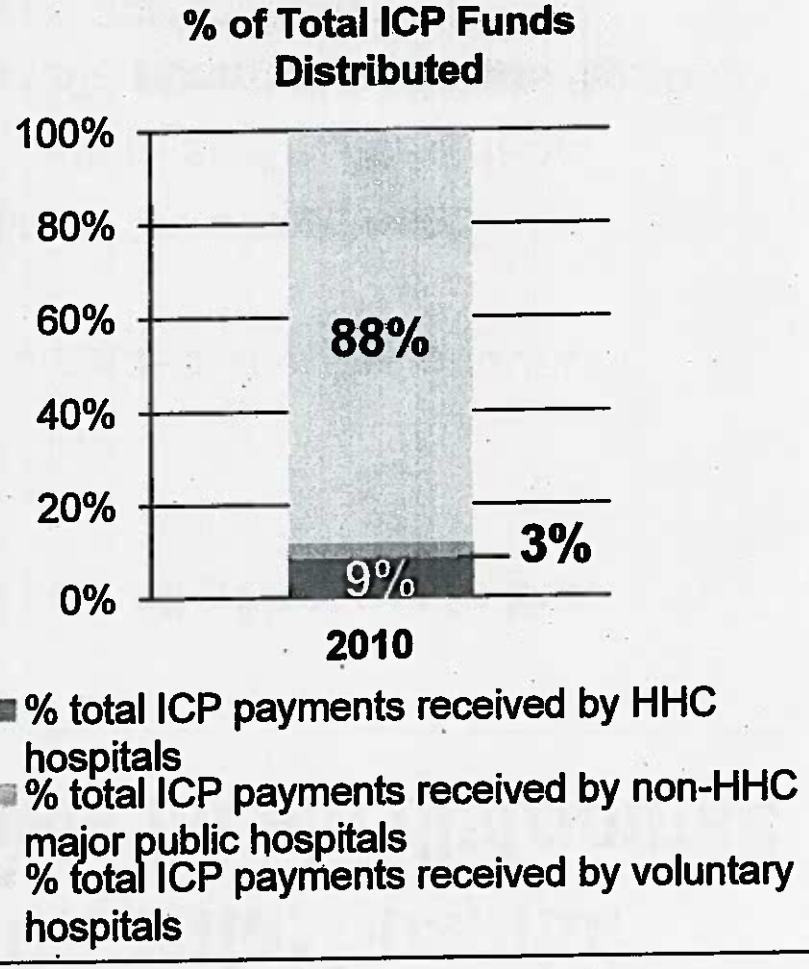
- Requested ICR data from the SDOH on all of hospitals that receive ICP funds.
- Analyzed the spreadsheets to determine:
  - Reporting of amount of financial aid provided and the amount of indigent care funds received;
  - Reporting on HFAL compared to claimed "targeted need":
  - Reporting on uncompensated care costs related to "bad debts";
  - Reporting on hospitals with CSS-identified barriers and liens taken on patients' homes v. number of approved applications.

What CSS found:

See next slides…

Public hospitals, who give the most financial assistance, get the least amount of indigent care funds





Note: Major public hospitals also receive an additional $1.5 B in UPL and IGT DSH payments.

The accuracy of costs reported for financial assistance recipients is questionable

Hospitals are required to report:

- Total costs for services to all uninsured patients
- Costs incurred in rendering services to uninsured patients eligible for financial aid (that were approved).
  - Patients eligible for financial assistance should be a subset of total uninsured .

However, CSS found that: Hospital reporting is patently flawed.

- Some report *more than* 100% of costs incurred on patients eligible for financial assistance than the total spent for all uninsured patients.
- Others report spending 0% on patients eligible for financial assistance.
- These numbers fluctuate each year.
  - 2007: 9 hospitals spent 100% to 419% on patients receiving FA; 9 spent 0%
  - 2008: 17 hospitals spent 100% to 826% on patients receiving FA; 9 spent 0%
  - 2009: 12 hospitals spent 100% to 482% on patients receiving FA; 18 spent 0%

Data on financial aid application approval rates is inconsistent across hospitals

Approvals:

- 119 hospitals approved more than 85%; 24 approved less than 50%; 3 approved none.

Denials:

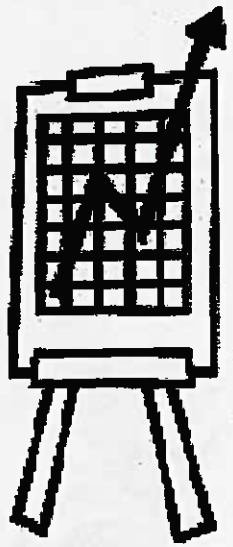
- 55 hospitals reported no denials; 37 reported denial rates of 10% or more.

Pending:

- 94 reported no pending applications; 28 had more than 10% pending.

Incomplete:

- 102 had no incomplete applications; 36 had more than 10% incomplete.



The amount of financial assistance given to patients does not correlate with ICP funds received.

Hospital Name	FA apps. approved (2008)	Indigent care funds rec'd per approved app.	# Apps. approved per certified bed (2008 apps, 2011 beds)
JACOBI MEDICAL CTR	52,702	$167	115.3
BELLEVUE HOSPITAL	69,636	$208	76.4
KENMORE MERCY	3,078	$308	16.7
MERCY HOSPITAL BUFFALO	8,583	$369	22.2
ST BARNABAS HOSPITAL	51,210	$561	114.8
STRONG MEMORIAL	15,480	$870	20.9
ERIE COUNTY MED CTR	3,706	$1,137	6.7
LUTHERAN MEDICAL CTR	29,761	$1,273	63.6
BRONX-LEBANON	18,549	$3,235	44.7
STONY BROOK	1,243	$5,104	2.2
MAIMONIDES	2,260	$7,870	3.2
KALEIDA HEALTH	683	$8,782	0.7
CORNING HOSPITAL	161	$13,892	1.6
ROCHESTER GENERAL	620	$20,176	1.2
MONTEFIORE	2,287	$21,093	2.0
JAMAICA HOSPITAL	1,365	$26,292	3.6
BETH ISRAEL MEDICAL CTR	691	$41,065	0.8
NYU HOSPITAL CTR	256	$41,984	0.2
LENOX HILL HOSPITAL	130	$84,469	0.2
BROOKDALE HOSPITAL	278	$93,929	0.5

Note: Major public hospitals also receive an additional $1.5 B in UPL and IGT DSH payments.

The statewide average number of apps approved per certified bed is 16.

Many of the top hospitals reporting the highest targeted need reported lower than average financial assistance distribution relative to their size

Hospital name	Targeted need (2010) [Cost in 90% method]	Apps approved (2008)	Apps approved (2008) per certified bed (2011)
MOUNT VERNON HOSPITAL	13.5%	1553	9
ELLENVILLE REGIONAL HOSPITAL	12.4%	12	0
JAMAICA HOSPITAL	10.8%	1365	4
CATSKILL REGIONAL MED CTR	10.3%	647	4
ST JOSEPHS HOSPITAL YONKERS	10.2%	157	1
SOUND SHORE WESTCHESTER	9.3%	1341	5
INTERFAITH MEDICAL CENTER	9.1%	2012	7
BROOKDALE HOSP MED CTR	8.1%	278	1
BON SECOURS COMM HOSP	8.0%	0	0
IRA DAVENPORT MEM HOSP INC	7.7%	159	4
MOUNT SINAI HOSPITAL OF QUEENS	7.3%	1187	5
SUNY HEALTH SCIENCE CENTER	7.0%	381	1
WAYNE HEALTH CARE	6.8%	130	1
MARGARETVILLE HOSPITAL	6.0%	48	3

The statewide average number of apps approved per certified bed is 16.

70% of hospitals reported that more than 50% of their uncompensated care costs were due to patient bad debts.

Hospital Name	% of uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	Apps approved per cert. bed
STONY BROOK	96%	$6,344,162	2.2
CORTLAND MEMORIAL	93%	$1,462,926	4.4
GLENS FALLS HOSP	92%	$6,321,820	2.5
NYU HOSPITAL CENTER	90%	$10,747,952	0.2
CORNING HOSPITAL	90%	$2,236,620	1.6
BETH ISRAEL MEDICAL CTR	89%	$28,375,694	0.8
JAMAICA HOSPITAL	89%	$35,889,008	3.6
BERTRAND CHAFFEE HOSP	86%	$412,954	0.0
BROOKDALE	85%	$26,112,334	0.5
SUNY DOWNSTATE	85%	$5,411,530	17.8
JOHN T MATHER MEMORIAL	85%	$2,344,368	5.2
NASSAU UNIV MED CTR	85%	$7,434,717	57.7
BROOKHAVEN MEM HOSP	82%	$7,680,614	2.8
ROCHESTER GENERAL HOSP	81%	$12,509,009	1.2
WYCKOFF HEIGHTS HOSP	75%	$20,510,496	23.1
ST LUKES / ROOSEVELT	74%	$37,643,016	9.4
ST BARNABAS HOSPITAL	17%	$28,708,796	114.8

The statewide average number of apps approved per certified bed is 16.

Hospitals with financial aid applications that include impermissible requirements are less likely receive and approve applications.

	App. without impermissible requirements	App. with impermissible requirements
# of Hospitals	161	36
# Apps. rec'd./ Hospital	6,574	2,024
% of total apps. received	93.6%	6.4%
% of total apps. approved	93.9%	6.1%
% of total apps. denied	77.8%	22.2%
% of total apps. pending	91.0%	9.0%
% of total apps. incomplete	92.0%	8.0%
% Apps. approved	95.2%	90.0%
% Apps. denied	1.3%	5.3%
% Apps. pending	1.3%	1.9%
% Apps. incomplete	2.2%	2.8%
Avg. # apps. approved / certified bed	18.0	7.8
Total ICP funds received	$1,051,354,685	$131,145,315

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The statewide average number of apps approved per certified bed is 16.

Many hospitals aggressively pursue collection of bad debt by placing liens on patient homes.

Hospital name	Total Liens (2008)	Liens per bed	Apps approved per certified bed	% of uncompensated costs due to bad debt	Total indigent care pool funds received
SUNY DOWNSTATE	1053	2.80	17.80	85%	$5,411,530
STONY BROOK	680	1.19	2.20	96%	$6,344,162
SARATOGA HOSPITAL	450	2.63	4.80	47%	$2,314,574
GOOD SAM HOSP / WEST ISLIP	406	0.93	40.10	16%	$8,480,429
MASSENA MEM HOSP	249	4.98	6.30	60%	$1,263,935
CROUSE HOSP-COMMONWEALTH	92	0.20	1.50	68%	$6,462,589
BROOKS MEMORIAL HOSP	77	1.18	8.80	74%	$606,969
VASSAR BROTHERS MEDICAL CTR	72	0.20	43.00	33%	$5,961,049
ROSWELL PARK MEMORIAL INST	71	0.53	1.10	69%	$2,227,030
UNITED HEALTH SERVICES, INC	70	0.15	5.00	78%	$8,005,842
ST FRANCIS HOSP POUGHKEEPSIE	68	0.20	18.80	45%	$4,304,773
CORTLAND REGIONAL MED CTR	66	0.37	4.40	93%	$1,462,926
ST JOSEPHS HOSP OF ELMIRA	66	0.29	1.60	89%	$1,221,417
NIAGARA FALLS MEML MED CTR	63	0.37	1.70	90%	$1,858,979
ORANGE REGIONAL MED CTR	52	0.12	0.70	88%	$2,778,459
CHAMPLAIN VALLEY PHYS HOSP	51	0.16	1.50	78%	$2,178,680
ERIE COUNTY MEDICAL CTR	44	0.08	6.70	54%	$4,213,019
NATHAN LITTAUER HOSP	38	0.51	15.10	82%	$2,244,666
OUR LADY OF LOURDES MEM HOSP	37	0.14	11.60	89%	$3,785,336

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The statewide average number of apps approved per certified bed is 16.

Impending funding issues

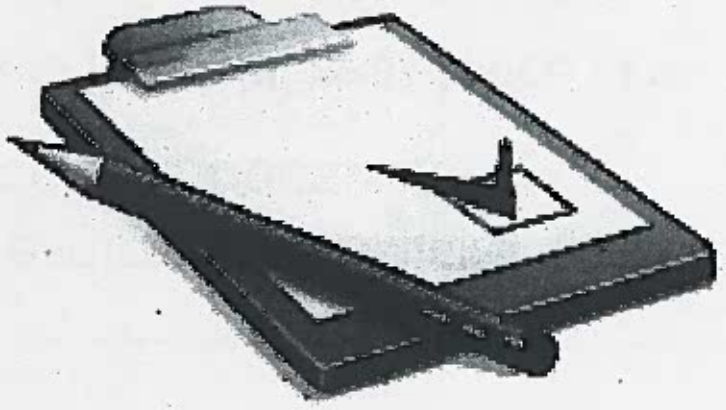
Changes to the federal indigent care pool funding source

- **New DSH audit requirements**: Federal DSH payments are supposed to be used only to reimburse hospitals for uncompensated care costs for Medicaid and uninsured patients. New DSH audit requirements are more stringent on this rule:
  - States are now required to submit more information to CMS on Medicaid and uninsured costs to ensure compliance (see Appendix C).
- **How this will affect New York:** Currently, New York uses two methodologies to calculate uncompensated care: BDCC and Units of Service (see slides 17-22).
  - Both include patients who are "uninsured" and "self-pay" under the same category.
  - Hospitals will need to separate these two categories when reporting costs.
  - Bad debts also will need to be reported separately from financial assistance.

Changes to the federal indigent care pool funding source

- **DSH cuts under the ACA:** The ACA reduces nationwide DSH funding yearly starting in 2014, for a total cut of 50% by 2019. Preference for funding will go to states that:
  - have high rates of uninsurance.
  - have high levels of uncompensated care for Medicaid and uninsured patients.
  - target DSH funds to hospitals with high Medicaid inpatient rates.
- **How this will affect New York:**
  - New York already accounts for 14% of the federal DSH payments nationwide but only 6% of the nation's uninsured. So, any cuts made to the total available will result in a significant cut for New York.
  - These cuts will have important policy ramifications both for targeting the use of the indigent care pool to maximize access to federal DSH funds, and for reallocating state funds previously used to match newly-cut funds.

Conclusions & Recommendations



Conclusion: Unlawful hospital policies hurt low-income New Yorkers by impeding access to financial assistance.

- Patients who are eligible for financial assistance under the law may never receive it because:
  - They do not know financial assistance is available.
  - They have difficulty finding information on how to apply.
  - Hospitals are imposing unlawful barriers that result in incorrect denials or deter patients from applying in the first place.

Conclusion: There is no incentive for hospitals to offer financial assistance vs. sending patients to collections.

- ICP payments are made to hospitals regardless of if losses are due to bad debt or for financial assistance provided.
- The vast majority of ICP funds are used to pay hospitals for patient bad debt rather than for providing financial assistance.
  - High levels of bad debt reported in relation to financial assistance given are a disservice to low-income New Yorkers.
- Opaque hospital reporting obscures real patient need.
  - Hospital reporting is difficult to comprehend, inconsistent, and inaccurate.

Recommendation: Improve guidance and Enforcement of the HFAL

- **There should be one single state-wide application used for financial assistance in New York.**
  - Uniform application should be developed by the SDOH.
  - SDOH should mandate all ICP hospitals to use uniform application.
  - SDOH's financial assistance policy summary template should be a "floor" that all hospitals must meet at minimum.
- **All hospital policies and the uniform application should be prominently posted.**
  - SDOH website should include all hospital policies and the statewide application.
  - Each hospital's website should include its own policy summary as well as the statewide application.
- **SDOH should perform statewide hospital audits & enforcement**
  - Hospital policies and procedures should be audited to ensure compliance with the law.
  - Hospital reporting data on financial assistance applications received, approved, denied, pending, or incomplete, should be audited to ensure accuracy in reporting.

Recommendation: Tie distribution of ICP funds to financial aid given

- **Incentivize hospitals to provide financial assistance:**
  - Hospitals should be required to process all uninsured and self-pay patients for financial assistance as a requisite for receipt of ICP funds.
  - Hospitals which provide financial assistance should be prioritized for ICP payments.
  - Any funds left in the ICP after reimbursement for financial assistance should be distributed to reimburse hospitals for bad debt.

Recommendation: Make the distribution mechanism for ICP funds more transparent.

- **Adopt a 100% units of service methodology for distribution of all ICP funds.**
  - Uncompensated care costs for uninsured and self-pay patients should be reported separately
  - This will allow the State to target ICP funds to New Yorkers who don't have insurance to cover the services they need.
  - This will maximize New York's ability to avoid federal DSH funding cuts.

Additional recommendations

- **Provide an enhanced allocation to hospitals with higher volumes of Medicaid patients.**
  - This will protect hospitals with a high volume of Medicaid patients from losses due to the adoption of the units of service methodology, which equates hospital costs with Medicaid rates.
  - Will offer some protection from further reductions in federal DSH funds.
- **Raise the floor for financial assistance.**
  - To comply with the ACA and current state law, the Hospital Financial Assistance Law should be revised to require hospitals to provide financial assistance up to 400% of FPL ($43,000 annually for an individual). The current asset test should also be removed.
  - More patients would benefit from getting financial assistance vs. being sent to collections.
  - Hospitals should continue to be allowed to offer financial assistance to patients with higher incomes if they so wish.

Long-term recommendations: Back-end issues

- **Allow pre-qualification for financial assistance.**
  - Starting with the launch of the statewide health insurance Exchange in 2014, New Yorkers who are uninsured and do not qualify for or cannot afford insurance products on the Exchange should be allowed to fill out a financial aid application annually to pre-qualify for financial assistance should they require medical care during the year.